

Northeastern University



**School of Law
Library**

COMMERCIAL HEALTH AND ACCIDENT INSURANCE INDUSTRY

HEARINGS BEFORE THE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY OF THE COMMITTEE ON THE JUDICIARY UNITED STATES SENATE NINETY-SECOND CONGRESS SECOND SESSION

PART 1A
PURSUANT TO S. RES. 256, SECTION 4

MAY 10 AND 11 AND JUNE 6, 7, AND 8, 1972

Printed for the use of the Committee on the Judiciary



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1973

90-319 O

For sale by the Superintendent of Documents
U.S. Government Printing Office, Washington, D.C. 20402
Price \$4.05 domestic postpaid or \$3.50 GPO Bookstore
Stock Number 5270-01813

NORTHEASTERN UNIVERSITY SCHOOL of LAW LIBRARY

Y4.J89
2: In 71
Pt. 1A

COMMITTEE ON THE JUDICIARY

JAMES O. EASTLAND, Mississippi, *Chairman*

JOHN L. McCLELLAN, Arkansas	ROMAN L. HRUSKA, Nebraska
SAM J. ERVIN, JR., North Carolina	HIRAM L. FONG, Hawaii
PHILIP A. HART, Michigan	HUGH SCOTT, Pennsylvania
EDWARD M. KENNEDY, Massachusetts	STROM THURMOND, South Carolina
BIRCH BAYH, Indiana	MARLOW W. COOK, Kentucky
QUENTIN N. BURDICK, North Dakota	CHARLES McC. MATHIAS, JR., Maryland
ROBERT C. BYRD, West Virginia	EDWARD J. GURNEY, Florida
JOHN TUNNEY, California	

SUBCOMMITTEE ON ANTITRUST AND MONOPOLY

PHILIP A. HART, Michigan, *Chairman*

JOHN L. McCLELLAN, Arkansas	ROMAN L. HRUSKA, Nebraska
SAM J. ERVIN, JR., North Carolina	HIRAM L. FONG, Hawaii
EDWARD M. KENNEDY, Massachusetts	STROM THURMOND, South Carolina
JOHN TUNNEY, California	EDWARD J. GURNEY, Florida

HOWARD E. O'LEARY, *Staff Director and Chief Counsel*

CONTENTS

WITNESS LIST

Amos, John B., president, American Family Life Assurance Co. of Columbus, Ga., accompanied by Malcolm Hoffmann, special counsel, and Kenneth Henson, general counsel-----	Page 1118
Bierschbach, Raymond A., vice president, Occidental Life Insurance Co. of California; accompanied by O. L. Frost, Jr., vice president-----	1035
Denenberg, Herbert S., commissioner, Pennsylvania Insurance Department-----	385
Fletcher, Mary Lynn, Knoxville, Tenn-----	450
Hemry, Leslie P., president, Health Insurance Association of America; accompanied by John Hanna, vice president and general counsel; Louis Orsini, director of the Health Insurance Council-----	1299
Hentges, Mrs. Judith, Dubuque, Iowa accompanied by Mr. Davis, Retail Clerks' Union-----	1279
Hook, Mrs. Ruth A. G., Clifton, Va-----	120
Johnson, Donald M., president, Aetna Life & Casualty Co., Hartford, Conn.; accompanied by Warren G. Elliott, general counsel; and Daniel G. Pettengill, vice president of Group Division-----	124
MacArthur, John D., chairman of the board, Bankers Life & Casualty Co., Chicago, Ill-----	293
Osborne, Mrs. Jeanette, Conley, Ga-----	895
Pabst, Edmund G., executive vice president, Combined Insurance Company of America, Chicago, Ill.; accompanied by Ronald K. Holmberg, senior vice president-----	460
Roemer, Milton I., M.D., University of California, Los Angeles, Calif-----	1019
Skutt, V. J., chairman of the board, Mutual of Omaha Insurance Co.; accompanied by Albert M. Hansen, senior executive vice president in charge of product and services-----	1179
Siegfried, Charles A., vice chairman of the board, Metropolitan Life Insurance Co., New York, N.Y., accompanied by William Thomas, executive vice president; Edwin B. Lancaster, Sr., vice president and chief actuary-----	902
Slater, Robert E., president, National Liberty Corp., Frazer, Pa., accompanied by William Paddy, general counsel and Donald Kennedy associate counsel-----	555
Wilberding, executive director, Medical Information Bureau, Greenwich, Conn-----	37
Woodcock, Leonard, president, United Automobile Workers, Detroit, Mich., accompanied by: Melvin A. Glasser, director, Social Security Department, and Max W. Fine, executive secretary, Health Security Action Council-----	4

EXHIBITS AND APPENDIX

New York Times, June 16, 1972, news item "Group Insurance Windfall Is Alleged"-----	25
Business Insurance of July 3, 1972, news item "Committee Says Health Insurers Had 'Windfall' Profits Because of Freeze"-----	26
Journal of Commerce of June 23, 1972, news item "HIAA Denies Allegations of 'Windfall'" by Leah Young-----	27
List of some insurance companies showing large increases granted by the Price Commission on group health and accident policies-----	28

Excerpt from contract performance review report of the Aetna Life & Casualty Insurance Co., Los Angeles office-----	Page 34
Excerpt from letter by R. E. Stewart, director, Medicare administration, Aetna Life & Casualty Co., to Mrs. Mercia Leton Kahn, regional representative, Bureau of Health Insurance, Social Security Administration, dated October 20, 1971, page 2-----	34
Photocopies of several pages of phone book "The Book of Names, Stamford and Vicinity"-----	50
"Health Insurance Experience-1970," Best's Review—life and health edition—November 1971, page 45-----	59
Medical Information Bureau list of member companies-----	60
Letter from Senator Philip A. Hart, chairman, Senate Antitrust and Monopoly Subcommittee, dated April 14, 1972, to Mr. Joseph C. Wilberding, executive director and general counsel, Medical Information Bureau-----	89
Letter from Joseph C. Wilberding, executive director and general counsel, Medical Information Bureau, dated May 2, 1972-----	90
Medical Information Bureau code list showing meanings of all code symbols used in their system-----	92
Medical Information Bureau schedule of charges, effective January 1, 1972-----	101
Medical Information Bureau, examples of MIB reports-----	102
"The History of the Automated M.I.B. System"-----	103
Letter from Mr. William R. Rapson, Davis, Graham & Stubbs, Denver, Colo., dated May 11, 1972, to Senator Philip A. Hart, chairman, Senate Antitrust and Monopoly Subcommittee-----	106
Letter from William R. Rapson, dated May 19, 1972, to Senator Philip A. Hart, chairman Senate Antitrust and Monopoly Subcommittee-----	106
Medical Information Bureau 1962 official code list of impairments-----	107
Medical Information Bureau rules, Appendix A-----	109
Aetna Life & Casualty, accident, health, and underwriting instruction manual, pages 121, 273, 275, 231c-----	134
Aetna Life & Casualty, accident, health, and underwriting instruction manual, page 267-----	137
New York Times article dated March 26, 1972, "'Nub City,' and Other Stories of an Insurance Investigator" by Barbara Davidson-----	139
Aetna Life & Casualty, accident, health, and underwriting instruction manual, pages 219, APP 216-----	145
Aetna Life & Casualty, accident and health insurance general underwriting instructions, page 129-----	149
Aetna Life & Casualty, accident and health insurance general underwriting instructions, page 421-----	152
Aetna Life & Casualty, accident and health insurance group underwriting manual, pages 4 and 5-----	153
Aetna Life & Casualty, disability income insurance underwriting instructions, partial list of occupations-----	154
Aetna Life & Casualty, accident and health insurance general underwriting instructions, moral hazards-----	157
Aetna Life & Casualty Insurance Co., "Book 2, Introduce Yourself to Health Insurance", page 70, field underwriting-----	164
Excerpts from "Analysis of Health Insurance Proposals Introduced in the 92d Congress," committee print, the Committee on Ways and Means, Table 9—Burlerson bill: Cost estimate, page 98; Table 6—Griffith-Corman bill: Cost estimate-----	165
Excerpts from hearings before the Committee on Ways and Means, House of Representatives, 92d Congress, first session on the subject of National Health Insurance Proposals, part 2, page 347-----	170
Aetna Life Insurance Co., accident and health policy experience exhibit for year 1970-----	173
Health and accident insurance questionnaires from Senate Antitrust and Monopoly Subcommittee, dated February 29, 1972-----	240
Questionnaires of Senate Antitrust and Monopoly Subcommittee Group and Individual Questionnaire-----	241
Individual Questionnaire-----	243

Companies' replies to Group Accident and Individual Health Insurance Questionnaire of Senate Antitrust and Monopoly Subcommittee:	Page
Question I.A.1.....	204
Question I.A.3.....	208
Question I.A.6.....	214
Question I.A.8. (and II.A.7.).....	180
Question I.A.11 and 12.....	220
Question I.A.13 and II.A.10.....	202
Question I.A.13.23.....	188
Question II.A.5.....	196
Question II.7. (also on same p. as I.A.8. above).....	180
Question II.A.11.....	203
Question III.A. and B.....	229
Companies' replies to Individual Accident and Health Insurance Questionnaire of Senate Antitrust and Monopoly Subcommittee:	
Question I.A.1, 2 and 3.....	182
Question I.A.5.....	218
Question I.A.7.....	221
Question I.A.10.....	220
Question I.A.11.....	228
Question II.A. and B.....	222
Aetna Life & Casualty Co. information on group health cases with Boeing, Chrysler, and International Harvester.....	254
Examination material—Actuarial Society of America, group insurance renewal rating ("study note").....	257
Aetna Life & Casualty Group underwriting manual, pages Gen. -63, -64, -65.....	261
"The Federal Employees Health Benefits Program, Enrollment and Utilization of Health Services 1961-68".....	264
Chart showing where the individual hospital surgical and medical premium dollar went in 1971, Bankers Life & Casualty Co.....	295
Excerpts from Bankers Life & Casualty, claim adjusters reference manual, book II, post claim underwriting.....	296
Letter from Peter A. Dammann, director, legal department, Bankers Life & Casualty Co., dated August 18, 1972, to Senator Philip A. Hart.....	300
Letter from Peter A. Dammann, director, legal department, Bankers Life & Casualty Co., dated August 25, 1972, to Senator Philip A. Hart..	301
Bankers Life & Casualty Co. underwriting manual pages 1, 2.....	306
Bankers Life & Casualty Co., annual statement for the year 1971.....	309
Schedule G of 1971 annual statement of Aetna Life Insurance Co. (including letter of May 5, 1972, from Donald M. Johnson, president of Aetna, to Senator Philip A. Hart, chairman of Senate Antitrust and Monopoly Subcommittee, showing breakdown of MIB medical service cost).....	310
Schedule G of 1971 annual statement of Continental Assurance Co., John Hancock Mutual Life Insurance Co., Metropolitan Life Insurance Co., Occidental Life Insurance Co. of California, Prudential Insurance Co. of America, Travelers Insurance Co.....	312
Bankers Life & Casualty Co., claim adjusters reference manual, book II: List of exceptions to company's medicare supplemental policies; senior citizens are deprived of company's Good Health Award; hospital charges not covered by company's medicare supplemental coverage, extended care not covered by company's medicare supplemental plans; procedures which may indicate company would like to get off risk in medicare supplemental coverages if policyholders condition appears to be likely to incur heavy medical expenses.....	317
Letter of April 19, 1972, from Peter A. Dammann, director, legal department, Bankers Life & Casualty Co., to Senator Philip A. Hart, in reply to Senator's letter of April 5, 1972.....	321
Letter of June 12, 1972, from Senator Philip A. Hart, chairman, Senate Antitrust and Monopoly Subcommittee, to Mr. Peter A. Dammann, director, legal department, Bankers Life & Casualty Co.; and Mr. Dammann's reply of August 3, 1972; pamphlet "The Gold Book"; Bankers Life & Casualty Co. policies: "Guaranteed Renewal Income Protection Policy; Guaranteed Renewable Hospital Indemnity Policy," policy form NC701.....	322

	Page
Case history: Mrs. Florence G. Acker and Bankers Life & Casualty Co.	352
Advertisements of Bankers Life & Casualty Co. for "Gold Book"; featuring Paul Harvey; directed at people under medicare	378
Press release of October 26, 1972, of Pennsylvania Insurance Department re commercial health insurers	419
"Health Insurance Booby Traps," article by Herbert S. Denenberg	444
Letter from Gerald H. Pugh, assistant vice president, Combined Insurance Co. of America, to Senator Philip A. Hart, chairman, Senate Antitrust and Monopoly Subcommittee, dated March 21, 1972	507
Table showing Combined Insurance Co. experience for calendar year 1971 in response to questionnaire	509
Annual statement for the year 1970 of the Combined Insurance Co. of America	510
Accident and health policy experience exhibit for year 1970 of Combined Insurance Co. of America	514
Accident and health policy experience exhibit for year 1970, annual statement of the Hearthstone Insurance Co. of Massachusetts	520
Combined Insurance Co. of America policy "Combined Little Giant Twenty-Five Dollar Semi-Annual Full Coverage Noncancellable Accident Policy"	525
Combined Insurance Co. of America major hospital-medical-surgical policy	529
Combined Insurance Co. of America Agency Division Bulletin January 16, 1972	535
Combined Insurance Co. of America Field Underwriting Kit	536
Combined Insurance Co. of America excerpts from "Underwriting"	537
Combined Insurance Co. of America memorandum to all general agents from teacher division underwriting	551
NH-10 claims data for 1970, 1971, and January and February 1972 on all NH-10 policies sold by National Liberty Corp. in 1970	598
National Liberty summary of computer-print-out of claims paid and rejected on NH-10 policies	599
National Liberty Corp. summarization of earned premiums, claims incurred and loss ratios of National Home NH-10	600
Actuarial tables, studies, projections furnished by National Liberty Corp. to SEC, State insurance departments, and Senate Antitrust and Monopoly Subcommittee	605
National Liberty Corp., comparison of total termination rates furnished in SEC prospectus with those given to State insurance departments	619
Table of national home examination of acquisition costs incurred on key health insurance plans	622
National Liberty Corp. annual report, 1971	626
Ten case histories of claims denied for preexisting conditions by National Liberty Corp.	664
Letter of July 5, 1972, to Senate Subcommittee on Antitrust and Monopoly from National Liberty Corp.	763
National Liberty Corp.: Use of persistency data for financial reporting and premium ratemaking	765
Regulatory status of National Home Life Assurance Co., July 5, 1972	768
National Home Life Assurance Co. extra cash hospitalization indemnity plan (standard)	770
National Home Life Assurance Co. hospitalization indemnity plan (Pennsylvania)	774
Letter of March 10, 1972, from Michigan Department of Commerce to National Home Live Assurance Co.	782
National Home Life Assurance Co. extra cash hospitalization indemnity plan (Florida)	783
Letter of July 31, 1969, from Florida treasurer's office to National Home Life Assurance Co.	787
National Home Assurance Co. of New York hospitalization indemnity plan	788
National Home Life Assurance Co. amendment rider (New Jersey)	792
National Home Life Assurance Co. amendment rider (Missouri)	792
National Home Life Assurance Co. hospitalization indemnity plan (Illinois)	793
National Home Life Assurance Co. extra cash hospitalization indemnity plan (California)	797
National Home Assurance Co. of New York hospitalization indemnity plan	800

National Home Life Assurance Co. advertisement "\$600 a Month Tax-Free Cash"-----	Page 805
Union Fidelity Life Insurance Co. advertisement "Extra Cash for People of All Ages Up to \$100-a-Week When You Go To the Hospital"-----	809
National Home Life Assurance Co. advertisement with Art Linkletter endorsement-----	817
National Home Life Assurance Co. advertisement for national home health plan-----	822
Letter of May 25, 1972, to Senate Subcommittee on Antitrust and Monopoly from National Liberty Corp. re modal premium payments-----	826
Table showing National Liberty Corp. all mass merchandised accident and health business sold in each year 1960 through 1970-----	827
Memo regarding National Liberty Group-----	828
Letter from New York Insurance Department, dated August 25, 1972, to Senator Philip A. Hart, chairman, Subcommittee on Antitrust and Monopoly-----	830
Letter from National Liberty Corp., dated September 5, 1972, to New York Insurance Department-----	830
Letter from National Liberty Corp., dated September 5, 1972, to Senate Subcommittee on Antitrust and Monopoly-----	831
Letter from Peat, Marwick, Mitchell & Co., dated January 4, 1971, to National Liberty Corp-----	831
"Why Do We Amortize Acquisition Costs Over 20 Years?" by W. Benjamin Weaver, vice president, Finance, National Liberty Corp-----	834
National Liberty Corp. registration statement filed with the Securities and Exchange Commission on August 26, 1971-----	837
"The 50 Largest Commercial Banking Companies," Fortune, May 1971--	886
"The 50 Largest Utilities," Fortune, May 1971-----	891
Metropolitan Life Insurance Co.: "Medical Impairment Guide for Hospital, Surgical, and Medical Expense Underwriting"-----	936
Letter from Metropolitan Life Insurance Co. dated July 10, 1972, to Senator Philip A. Hart, chairman, Senate Antitrust and Monopoly Subcommittee-----	946
Metropolitan Life Insurance Co.: "Personal Health Insurance Underwriting Rules"-----	948
Metropolitan Life Insurance Co.: "A Guide to Effective Administration of Group Health Insurance Plans"-----	952
Metropolitan Life Insurance Co.: "Group Insurance Training Guide"-----	958
Metropolitan Life Insurance Co.: "Group Insurance Manual Rate Section"-----	959
Metropolitan Life Insurance Co.: "Underwriting Guides Covering Hospital Employees" Re: volume adjustment-----	961
Metropolitan Life Insurance Co.: "Underwriting Guides Covering Clergy"-----	963
Metropolitan Life Insurance Co.: Material distributed to group claim consultants-----	963
Metropolitan Life Insurance Co.: Cooperative administration of group health insurance plans-----	965
Statement to the Subcommittee on Antitrust and Monopoly of the Committee on the Judiciary of the U.S. Senate concerning Metropolitan Life Insurance Co. and Medical Information Bureau-----	967
Metropolitan Life Insurance Co.: Group insurance manual, "Other Coverages Required," with group hospitalization-----	968
Metropolitan Life Insurance Co.: Excerpt from health rate book "Personal Health Insurance," plan descriptions and underwriting rules-----	969
Meeting May 5, 1972, between the Bureau of Health Insurance regional office, SSA, San Francisco, and Occidental Life Insurance Co-----	1045
Occidental Life Insurance Co. health insurance underwriting supplement, pages 310, 310A, and 204-----	1052
Occidental Life Insurance Co. health insurance underwriting supplement, page 380, "Inquiries to Other Companies"-----	1055

Occidental Life Insurance Co. health insurance underwriting supplement, page 1052 "Use of R.U. System"; pages 1080 and 1080A "M.I.B. Code Procedure"-----	Page 1056
Occidental Life Insurance Co. health insurance underwriting supplement, page 615 "Medical Expense--Gambling Occupations"-----	1058
Occidental Life Insurance Co. health insurance underwriting supplement, page 240, "Pregnant Wives on Family Coverage"-----	1059
Page 7 of meeting between the Bureau of Health Insurance regional office, SSA, San Francisco, and Occidental Life Insurance Co.-----	1061
"Contract Performance Review," Occidental Life Insurance Co., Los Angeles, Calif, July 20-24, 1970-----	1062 and 1067
Letter from Occidental Life Insurance Co. of California, dated June 16, 1972, to Senator Philip A. Hart, chairman, Senate Subcommittee on Antitrust and Monopoly-----	1066
Occidental Life Insurance Co. of California, memorandum of June 6, 1972, to Dean Sharp, subcommittee staff, re 314(b) query-----	1075
Comprehensive Health Planning Association of Los Angeles County, Los Angeles, Calif., "Sources of Funds, Estimate, 1972"-----	1076
Los Angeles County Comprehensive Health Planning Association board of directors, consumers-----	1076
Occidental Life Insurance Co. of California memorandum from A. B. Halverson, senior executive vice president, dated June 20, 1972, to Raymond A. Bierschbach, executive vice president and actuary-----	1080
Occidental Life Insurance Co. of California, material concerning conversion privilege-----	1081
Newsclip from Washington Evening Star, May 31, 1972, page A-7, column 4-----	1104
Schedule E, annual statement for the year 1971 of the Occidental Life Insurance Co. of California-----	1108
Occidental Life Insurance Co. of California memorandum dated June 21, 1972, from policy benefits division to Raymond A. Bierschbach, executive vice president and actuary, re 1971 health insurance claims paid-----	1114
Occidental Life Insurance Co. of California group field bulletin, dated March 17, 1970, subject: "Select Risk Underwriting" (confidential)-----	1116
Occidental Life Insurance Co. of California group field bulletin, dated July 30, 1970, subject: "Miscarriage Benefit"-----	1117
Occidental Life Insurance Co. of California, post-claim underwriting-----	1117
Table showing calculation of weighted loss ratios, American Family Life Assurance Co. of Columbus-----	1154
American Family Life Assurance Co. of Columbus, cancer policy and materials-----	1407-1414
Letter from Mrs. Francine Davis dated June 1, 1972, to Senator Philip A. Hart, and attached copy of Washington Post article of May 12, 1972-----	1157
Table: "Hospital Discharges--U.S. 1968, Length of Stay in Hospital"-----	1158
Letter of June 9, 1972, from John B. Amos, president, American Family Life Assurance Co. to Senator Philip A. Hart-----	1171
News item by Bob Woodward, Washington Post, June 8, 1972: "Pentagon Health Plan Criticized"-----	1172
American Family Life Assurance Co. of Columbus, accident and health policy experience exhibit for year 1971-----	1169
Mutual of Omaha information to personnel concerning settlements-----	1215
Letter from Mutual of Omaha dated May 23, 1972, to Senator Philip A. Hart, chairman, Senate Antitrust and Monopoly Subcommittee-----	1218
Mutual of Omaha information concerning risks-----	1221
Mutual of Omaha memorandum regarding information on administrative costs-----	1238
Mutual of Omaha memorandum regarding efforts to control underlying costs of providers (of health care)-----	1243
Mutual of Omaha memorandum from investment department to Mr. V. J. Skutt, chairman of the board-----	1246
Mutual of Omaha occupational rate manual-----	1261
Reprint of editorial dated May 8, 1967, from AMA News-----	1274
Mutual of Omaha--Individual Claims Procedural Manual--part I (franchise group contracts)-----	1275

Mutual of Omaha—Individual Claims Procedural Manual—part I (Retail Credit Company and Fair Credit Reporting Act)-----	Page 1277
Mutual of Omaha—Individual Claims Procedural Manual—part I (Sherman antitrust law)-----	1278
"The Health Care Crisis—A Study on Human Tragedy," a supplement to the October 26, 1971, testimony of AFL-CIO President George Meany before the House Ways and Means Committee-----	1284
Memorandum of Claudia B. Galiher of Health Services and Mental Health Administration, October 20, 1970, re attendance at St. Louis, Mo. meeting on financing of CHP, October 15-16, 1970-----	1325
Insurance company representation on section 314(a) Health Planning Advisory Councils, taken from comprehensive health planning reports as of 1971-----	1336
Health planning executive committee, Fort Smith, Ark-----	1336
City of New York Comprehensive Health Planning-Organizational Task Force biographical statement-----	1337
Tucson, Ariz., list of health planning council members-----	1337
List of Community Service Council, Inc. Community Health Planning Commission, Birmingham, Ala-----	1338
Mid-Ohio Health Planning Association, Columbus, Ohio, list-----	1340
List of members of Comprehensive Health Planning Association of the Greater Ottawa Valley, Lima, Ohio-----	1349
List of members of Arcawide Comprehensive Health Planning in the Central Ohio River Valley (Ohio, Indiana, and Kentucky)-----	1354
Executive Committee of Health Planning Association of Northwest Ohio (Maumee)-----	1360
Upper Peninsula Areawide Comprehensive Health Planning Association, Marquette, Mich., summary local financial contributions-----	1360
Area Matching Funds, Omaha, Nebr-----	1361
Flint, Mich., 1972-73 GLS funding schedule-----	1362
Comprehensive Health Planning Agency of Southeastern Wisconsin, Inc., Milwaukee, Wis., re fund raising-----	1362
Comprehensive Health Planning Council of Southeastern, Mich. (Detroit)-	1363
Local income forecast, fiscal year 1971-72, Comprehensive Health Planning Council of Spokane County, Inc., Wash-----	1364
Lower Columbia Regional 6-A, Clark, Skamania, and Klickitat Counties, Wash., source of financial income-----	1364
Twin Cities, St. Paul-Minneapolis, Minn. Detailed budget, December 1, 1971 through November 30, 1972-----	1365
Local Share Fund Raising, to establish a Comprehensive Health Planning Agency and Program for Northern, N.J. (Bergen, Hudson, Passaic and Sussex Counties)-----	1365
Health Planning Council of Greater Miami Valley, Dayton, Ohio-----	1366
Health Planning Association of Northwest, Ohio, Maumee, Ohio-----	1367
Southeastern Ohio Health Planning Association, Budget Justification, Cambridge, Ohio-----	1367
Southwestern Michigan Comprehensive Health Planning Association, St. Joseph, Mich., financial report for the second year organizational grant (proposed)-----	1368
Department of Health, Education, and Welfare, Public Health Service, Notice of Proposed Revision of Regulations for Grants to States for Comprehensive Health Planning-----	1369
Letter from Philip A. Hart, chairman, Senate Antitrust and Monopoly Subcommittee, dated May 26, 1972, to Health Insurance Association of America-----	1375
List from Health Insurance Association of America of those serving on "A" Agency and "B" Agency, by States-----	1375
Excerpts from "Group Insurance Manual," John Hancock Mutual Life Insurance Co-----	1380-1406
Chart—"Personal Health Services Estimates for 1974—Present System vs. Bureson-McIntyre Bill"-----	1387
Chart—"Individual Disability Income Premium Dollar-Combined Insurance Group"-----	1388

HEARINGS ON COMMERCIAL HEALTH AND ACCIDENT INSURANCE INDUSTRY

TUESDAY, JUNE 6, 1972

U.S. SENATE,
SUBCOMMITTEE ON ANTITRUST AND MONOPOLY
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met at 10 a.m., in room 2228, New Senate Office Building, Senator Philip A. Hart presiding.

Present: Senator Philip A. Hart.

Also present: Howard O'Leary, chief counsel; Dean E. Sharp, assistant counsel; Peter N. Chumbris, minority counsel; Charles Kern, staff of Senator Fong; Patricia Barro, editorial director, and Janice Williams, chief clerk.

Senator HART. The committee will be in order. Senator Hruska was able to be here for a few minutes before we began, but is required, because of another committee operation, to be absent now.

We will be joined by Senator Gurney.

It is my understanding that we are permitted to open in order that our schedule may be followed.

The first witness this morning is the president of National Liberty Corp., Frazer, Pa., Mr. Robert E. Slater.

Mr. Slater?

I ask that the statement of Mr. Slater be printed in the record at this point.

(Document follows. Testimony resumes on p. 583.)

BIOGRAPHICAL SKETCH OF ROBERT E. SLATER

Mr. Robert E. Slater was born in New York City. He has spent his entire working career in the life insurance industry.

Mr. Slater first started as an office boy with the New York Life Insurance Co. While there, he studied for the actuarial examinations and is now a Fellow of the Society of Actuaries.

During World War II, Mr. Slater served four years as a Naval Aviator in the Pacific Theater.

After the war, Mr. Slater moved to Boston and the John Hancock, rising from Research Assistant to President and Chief Executive Officer on January 1, 1966. At the end of 1969, he resigned from that office.

During late 1970 and most of 1971, Mr. Slater was President of Investors Overseas Services, located at Geneva, Switzerland. In September, 1971, he returned to the States as Chairman of the Board of National Liberty Corp.

STATEMENT TO THE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY BY ROBERT E. SLATER, NATIONAL LIBERTY CORPORATION

INTRODUCTION

My name is Robert E. Slater. I am Chairman of the Board of the National Liberty Corporation and of its insurance subsidiaries, National Home Life As-

Insurance Company of Missouri, National Liberty Life Insurance Company of Pennsylvania and National Home Assurance Company of New York.

I joined National Liberty on a full-time basis on October 1, 1971. This does not mean that I am a newcomer to the insurance business. Since early 1970 I have been a member of the Board of National Liberty and Chairman of its Executive Committee. Prior to that time, I was President and Chief Executive Officer of the John Hancock Mutual Life Insurance Company, one of the Nation's largest life insurance companies. I have been in the insurance business since 1934 and I am a Fellow of the Society of Actuaries.

I appreciate very much the opportunity to appear before this Subcommittee to help answer some of the questions being asked about health insurance coverage. As I listen to the many statements being made and read the many articles appearing in the news media, I am concerned about the extent of the misinformation as to the nature and methods of distribution of health insurance.

Ruskin said, "The work of science is to substitute facts for impressions and demonstrations for appearances." I trust my remarks today will help clear up some of these misunderstandings.

CONSUMER PROTECTION

The focus of the Committee's inquiry is consumer protection—Is the public well and fairly served by the health insurance industry which acts as a fiscal intermediary in the health care delivery system? Our companies communicate by mail and telephone with over one and a half million policyholders on a day to day basis, and through these daily contacts we have become sensitive to the wants and needs of these consumers. That we have been successful in identifying and satisfying many of their desires is demonstrated by the fact that between 1967 and 1971 the number of our policyholders and our premium receipts have more than tripled, and during the first four months of 1972 we issued more than 300,000 accident and health insurance policies—more than 3,700 per working day.

During the relatively short period of our existence our paramount concern for the consumer has found expression in the continual improvement of our products and the introduction of new health insurance products to protect the public against the often tragic consequences of illness and accident. The health care wants and needs of the public are constantly evolving, of course, and it is our intention to continue to identify and satisfy as many as possible of these desires by offering new forms of protection as well as improvements in existing policies. I will discuss some specific examples in a few minutes.

HEALTH CARE COSTS AND INSURANCE PROTECTION

Costly advances in medical technology coupled with severe and persistent inflation in the price of traditional services and facilities has put the cost of catastrophic and even major illness beyond the financial capacity of all but our wealthiest citizens.

Thus, the New York Times on February 27, 1972, stated, "Hearings by Congressional committees have produced hundreds of stories detailing the effects of costly illnesses on the savings of families, in many cases in spite of some sort of insurance coverage."

This Committee is well aware that health care costs are rising rapidly. And Chart 1 shows that in spite of the tremendous sums spent for health insurance by the American people, of the \$67 billion of health care costs in 1970, \$25 billion, or approximately 37%, was paid by individuals directly out of current income or savings. Government provided benefits of 40% and 23% was paid for by private insurance company benefits.

Chart 2 shows the various categories of health care costs and the percentages not covered by any form of insurance. While the chart does indicate that approximately 80% of in-hospital services are provided for by private insurance and/or Government, high percentages of out-of-hospital medical and dental care are not provided by either private insurance or Government.

Furthermore, like the portions of an iceberg invisible below the surface, there are the medical needs of many of our citizens whose illnesses never enter into the cost picture because they avoid seeking treatment which they cannot afford, as well as the many incidental costs incurred when there is a serious illness that are not strictly medical costs.

The health insurance protection of *many* Americans would appear to be inadequate when measured by the breadth and depth of coverage. Mass marketed supplemental policies attempt to remedy both deficiencies. This form of insurance helps fill in the gaps in protection left uncovered by basic policies. It also provides some protection for persons not presently served under traditionally marketed insurance, and at a price they can afford.

SUPPLEMENTAL HOSPITAL INDEMNITY INSURANCE

References to insurance written by the National Liberty Group will be limited to supplementary accident and health insurance mass marketed through direct-response advertising. Although the Group does market policies providing basic coverages through agents, it emphasizes the mass marketing of supplemental indemnity coverages, and these policies account for the vast bulk of the Group's premium income.

At this time I would like to submit to the Committee a booklet entitled "Supplemental Hospital Insurance and the Public Interest." This booklet explains in some detail the principles underlying this newly developed private insurance product, how it is marketed and how it serves the public interest. It contains some materials not covered in our oral and written submissions, and I therefore request that it be included in the record of these hearings.

Let me describe a little more fully Supplemental Hospital Indemnity Insurance. It provides specified cash benefits to the policyholder for each day he is hospitalized, and it may also provide specified benefits for surgery, dismemberment, nursing services, etc. The average premium per policy is approximately \$70 as compared to \$350 for an individual basic health insurance policy. Benefits vary from \$20 to \$30 per day of hospitalization. It is not basic medical reimbursement coverage. It is *supplemental* insurance. In fact, our studies show that more than 80% of our policyholders have other coverage such as Blue Cross or Group Insurance. In other words, basic coverage does not cover all medical costs and individuals obtain additional coverage to help defray the cost of illness as well as those costs incidental to illness.

Supplemental Hospital Indemnity Insurance is not intended to cover direct medical costs or the basic health insurance coverages, but rather the additional expenses not covered because of the gaps, exclusions and limitations of basic coverages, and those expenses incidental to medical costs. The benefits are, however, related to a stay in a hospital, since this indicates a serious illness and the need for money to meet the costs incidental to such serious illness. Although basically a supplement to help fill in the gaps in basic coverage, our policies are purchased by some who cannot afford more costly basic coverages, and for such persons are obviously better than no coverage at all.

ADVERSE SELECTION

The Subcommittee has expressed interest in clauses which limit benefits to the policyholder. The limitations are included in the policies primarily to make it feasible to write the business and eliminate the adverse selection that would otherwise be created for the benefit of the few. Insurance is primarily a sharing of risk of loss by a group of individuals to avoid the necessity that each individual assume his own losses. In order for any kind of voluntary program to be successful in a free society, it is necessary to include as much individual equity in the setting of premium rates as is possible. People do not wish to pay more than a fair share of the total cost. This is true in most everything and is not peculiar to insurance. Consequently, the cost of life and health insurance, for example, increases by age at the time of issue to take into consideration the fact that it is probable that losses will increase as a policyholder ages.

The same principles apply to health insurance. In order to prevent anti-selection, different methods of underwriting are employed. Each has been devised for a particular form of coverage. In Blue Cross and Group Insurance underwriting restrictions take a simple form. They typically require that 75% of employees of a given employer join the plan and that the individual be at work when enrolled, i.e., is in good enough health to be actively at work. There is also a limited period of time in which an individual can enroll. In this way, since all in a particular age bracket pay the same premiums, they are assured of getting a fair share of the benefits since all will be in roughly the same state of health.

Under the traditional individual contract a medical examination has generally been required in order to avoid adverse selection—i.e., applications for coverage by persons already or chronically ill, since coverage of such persons would necessarily increase rates unfairly for those in normal good health. The carrier underwrites each application, and will charge an extra premium, waiver out coverage for specific illnesses or deny coverage when the applicant has known medical problems. Underwriting on a person by person basis is obviously a costly procedure.

PRE-EXISTING CONDITION PROVISION

Under Supplemental Hospital Insurance distributed by mass marketing techniques, on the other hand, underwriting is eliminated through the use of the pre-existing condition concept. No medical examination is required, and coverage for known medical conditions is not "waivered" or "rated". A pre-existing condition that is manifest (or in some states, treated), will simply not be covered for a two-year period. Coverage, however, is granted to all who sign the application and pay the premiums. The premium varies only by age, and there is no distinction based on race, color, creed, sex, occupation or condition of health. After the two-year period, coverage is extended even to pre-existing conditions as though the policyholder's health had not been impaired at time of issue.

This simple protection against adverse selection, which is fully explained in the advertising copy and the enrollment form, makes possible a form of mass marketed group insurance similar to the group concept available to everyone, including many who could not be served economically on a person-to-person basis by agents.

Some look upon a pre-existing conditions clause as a drawback. We believe this is because they have not taken the trouble to understand it. Actually, it permits insurance coverage to individuals who would not otherwise be eligible—a kind of group insurance for the masses—and we believe it is a truly important breakthrough in insurance concepts.

We were all impressed, I know, by the moving testimony of Miss Mary Lynn Fletcher (N.T. pp. 375 et seq.) who has so courageously faced adversity. If Miss Fletcher were to have applied for a mass merchandised accident and health policy issued by the National Liberty Group, her application would have been accepted irrespective of any physical impairment she might have had, and her policy would have been guaranteed renewable for life. Her premium rates would have been totally unaffected by her medical history or her sex. Her youth, in fact, would have entitled her to the most favorable premium rate. No condition would have been waived. No provisions in her policy would have operated to limit in any way her recovery of benefits for accidental injury. The only limitation of Miss Fletcher's benefits would have been that for two years after policy issue, hospital confinement for treatment of a condition treated or manifest prior to issue would not have been covered.

EXCLUSION PERIODS

National Liberty offers policies which provide for first-day coverage as well as three and five-day waiting periods. The waiting period provisions are in response to announcements by many (including Commissioner Denenberg and the Department of Health, Education and Welfare) that deductibles were favored to assist in combating inflation and eliminating small claims. Such provisions are in keeping with the traditional purpose for insurance—protecting against the unusual (rather than the normally expected) loss. Policyholders may elect, however, to purchase first-day coverage.

OUTPATIENT CARE

The suggestion has been made that health insurance policies generally should provide coverage for outpatient and other nonhospital care. We are inclined to agree; however, we are not of the view that these coverages should be sold as a part of supplemental insurance.

Our company has been willing to study the possibility of selling by mass merchandising techniques policies with benefits unrelated to hospital confinement. To date, however, we have held the view that the primary purpose for

supplemental health insurance is to help protect the insured against catastrophic loss suffered as a consequence of illness, and that catastrophic loss is normally directly proportional to hospital confinement. Loss of time policies, workmen's compensation and some basic health insurance policies provide coverage for losses not related to hospital confinement. It must be recognized that to the extent benefits unrelated to hospital confinement are offered, claims handling expense (and consequently cost to the insured) would be increased substantially.

SPECIFIC QUESTIONS

Let me now turn to some of the specific questions asked in the Chairman's letter dated March 15, 1972 and those raised in the first two days of hearings on May 10 and 11.

LOSS RATIOS AND BENEFITS

You have asked whether insurers are returning a sufficient share of their premiums in benefits.

This leads to the question. "Why do some companies pay out 95% in claim benefits while others pay out considerably less?"

To answer these questions it is necessary to understand the major methods of operation and the different purposes for the specific coverages being offered in the private sector today.

Chart 3 compares the four major kinds of health insurance coverage presently offered by the private sector.

Column I lists eight principal features of health insurance, and by reading across it is possible to compare the products, the method of distribution, and the administrative characteristics, etc. It is the differences in these basic features that account for the variations in the premiums/claims ratios (loss ratios) of the four types of carriers. In general, let me make these points:

(a) Those coverages that are sold to an employer for the benefit of his employees, such as Blue Cross and Group Insurance, and which do not guarantee premium rates for any long period of time will have lower expense rates and pay higher claim benefits as a percentage of premium payments.¹ This is so because many of the expenses of the coverage are paid by the employer rather than the carrier), and because it is not anticipated that rates will be in effect for very long but are subject to change if loss ratios are excessive. For example, Blue Cross in Philadelphia, which had nine (9) rate increase in the 1960 decade, applied for a 39% increase effective April 1st, and was granted a 19.5% increase by the Pennsylvania Insurance Department. This, let me add parenthetically, is in spite of the glowing reports we heard last month about the tremendous improvements in the operation of Philadelphia hospitals. Similarly, the Price Commission has just recently approved rate increases on Group Health Insurance for three major carriers on the order of 20-32%. Marketing costs are relatively low because the carrier makes a single sale to the employer rather than a multitude of individual sales, and new business is created without additional marketing costs to the carrier as the number of employees grows.

Administration expenses are also largely absorbed by the employer. To put it in its simplest terms, this kind of coverage is really on a cost-plus basis and can hardly be called insurance in the true sense of the word. The employer is even expected to make up any unusual losses that might occur. (See e.g. N.T. pp. 211 et. seq.) The cost of marketing and much of the cost of administering either Blue Cross or a Group Insurance Plan is thus passed on to the public by the employer through the cost of its product, even though that cost is not reflected in the premium figures. It is misleading, therefore, to compare the costs of Blue Cross and Group with individual insurance without revealing the hidden costs. If these figures were included, the claim ratios would of course be lower for Blue Cross and Group Insurance.

In fact, the figures for relatively small Group Insurance or Blue Cross plans approximate those of individually sold contracts marketed by mass merchandising techniques.

¹ It may interest you to know that our principal carrier, National Home, also sells Group Insurance and has the same high claim payout rate as other group carriers.

(b) Under individual contracts, rates and benefits are established for long periods of time, especially in the case of supplemental coverage. While claim ratios in the early policy years will be low, they build up as each block of business ages. This pattern is uniformly true of health insurance as well as life insurance. I will discuss this in more detail when explaining premium calculations and accounting.

PREMIUM CALCULATION IN LONG-TERM COMMITMENTS

Let me now for a few minutes discuss the profitability of the supplemental hospital insurance business, which makes long-term commitments. Whether an insurance company engaging in this business will make a profit and how much, and whether the policyholders can expect an adequate return over the life of their policies, cannot be determined from one year's figures. The loss ratios that have been referred to in the press lately as indicating that the direct mail insurers pay out too little in benefits and in turn have exorbitant profits, are misleading.

The Annual Statement, from which these figures have been taken, is a combination of statistics selected to indicate to the regulatory authorities whether or not a company could meet its commitments to policyholders if the company were to be liquidated immediately. Although the Annual Statement is an important document for this purpose, it cannot be used without careful analysis to determine whether premium rates are reasonable, especially for a company engaged in long-term commitments.

Several commentators have been quoted in the press as stating that insurers of individual health insurance contracts pay out too little in benefits and in turn have exorbitant profits. The loss ratios quoted in the context of these stories are usually derived from one year's business, often the experience of policies recently issued. As such, these statements and the loss ratios on which they are based are misleading.

The analysis of annual statement figures is not easy. Dr. Kulp, former Dean of the Wharton School, said, "The materials available for analysis, particularly loss and underwriting ratios are, even in the hands of experts, of very little help. The moral is not that loss and underwriting ratios are to be ignored, but that the greatest caution is required in translating them into standards for judging the adequacy and the reasonableness of premiums."

Chart 4 shows the loss ratios that morbidity experience indicates will occur and are assumed in premium calculations by the National Liberty Group of Companies. The expected loss ratio is 35% in the first and second year, and increases 5% a year thereafter. Taking all policy years into consideration, premiums collected and claims paid for a given year of issue, it is anticipated that the company will pay out over the life of the business, 55-60% of all premiums in claims to the policyholder. As you will see later on our actual experience for 1960 and 1961 business exceeds considerably these anticipated results.

In dotted lines on this same chart is the actual experience of the National Liberty Group of companies. We have taken all claim experience by year of issue for the National Liberty companies since 1960 and combined them to get the overall result. Because of the peculiarities of a deviated premium for the first month of issue in some states, the first and second year experience has been combined. The first and second years' experience is just slightly below the expected results; whereas, for all other years, the actual experience has exceeded the anticipated results.

Most State Insurance Departments will not approve policies for sale if they do not provide actuarially for this level of claims payments to policyholders. The New York State Insurance Department, for example, requires a 60-65% cumulative claim payout for policy approval on ages at issue over 60. Pennsylvania requires a 50-55% ratio. New York grades companies from A+ to F in anticipated cumulative loss ratio and under this standard National Liberty Companies rate A+. The cumulative loss ratio for individually underwritten health insurance coverage is the only proper method of determining the fairness to the public of a specific policy coverage.

Some companies have withdrawn from writing individually underwritten business in New York because they cannot meet the loss ratio requirements. Our Corporation, on the other hand, formed a new company in New York during 1971, which has an A+ rating in claims, and our policies are receiving wide acceptance in that State.

I have inserted the next chart in the text as page 14(a) because it would be difficult to read if attached as an exhibit with the other charts. It shows Earned

EXHIBIT 1
NATIONAL LIBERTY GROUP POLICY EXPERIENCE YEARS

Policy issue year	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	Cumulative
1960:												
Earned premium (dollars)	215	859	713	661	600	465	422	395	380	367	343	5,420
Incurred claims (dollars)	83	318	375	428	384	383	386	343	355	316	280	3,654
Loss ratio (percent)	40	37	53	65	64	82	91	87	93	86	83	67
1961:												
1961:												
Earned premium (dollars)		1,345	3,524	2,841	2,451	1,857	1,656	1,546	1,477	1,418	1,323	19,438
Incurred claims (dollars)		548	1,352	1,551	1,485	1,335	1,277	1,198	1,161	1,126	1,051	12,084
Loss ratio (percent)		41	38	55	61	72	77	77	79	79	79	62
1962:												
Earned premium (dollars)			2,290	4,354	3,365	2,436	2,206	2,057	1,979	1,909	1,790	22,436
Incurred claims (dollars)			1,014	1,613	1,506	1,563	1,424	1,331	1,292	1,262	1,187	12,192
Loss ratio (percent)			44	37	45	63	65	65	65	66	66	54
Year: Earned premium (dollars)		2,204	6,527	9,784	10,685	11,161	15,187	18,607	21,363	28,939	40,968	165,440
Total: Incurred claims (dollars)		86	2,741	4,313	4,683	5,322	6,982	8,504	9,809	12,537	17,311	73,154
1960-70: Loss ratio (percent)		40	42	44	44	48	46	46	45	45	43	44
Cumulative year: Earned premium (dollars)		2,419	8,946	18,730	29,415	40,576	55,763	74,370	95,933	124,827	165,440	
Total: Incurred claims (dollars)		86	3,693	8,006	12,689	18,011	24,993	33,497	43,306	55,843	73,154	
1960-70: Loss ratio (percent)		40	41	43	43	44	45	45	45	45	44	

Note: Earned premium and incurred claims are shown in thousands; loss ratio equals incurred claims divided by earned premium. Does not include certain accident policies. These are estimated to account for approximately 2 percent of earned premium.

Premiums, Incurred Claims and Loss Ratios for each year 1960-1970. In addition it breaks out the figures for 1961, 1962 and 1963 so that you can see the loss ratio for each calendar year. Also on the extreme right there are cumulative figures for the particular years of issue and all years combined.

These figures indicate that on its seasoned business National Liberty is well above the industry and regulatory benchmarks of an ultimate 50%-55% loss ratio. The trend in other years of issue indicates the same ultimate results as our experience to date.

The National Liberty Group is making a substantial profit, but the profits are derived from the large volume of policies written rather than the profit earned per policy. In fact, we are probably currently writing more new premium income on individual policies than any other stock company in America and more than all but the three or four largest mutual companies.

The function of a Corporation in my opinion is to perform a service to society. For the efficient performance of that service it is entitled to and should earn a profit. In the insurance business, like every other business, the greater the risk assumed, the greater should be the permitted profit potential. Companies that set rates and guarantee coverages for long periods of time should have profit potentials greater than companies that insure on a year-to-year basis. Coverages sold to employers for their employees generally have rate adjustments on a yearly basis. Almost all policies sold by National Liberty are guaranteed renewable for life; i.e., we cannot cancel the coverage. Although we can raise rates on a statewide basis, our premium rates have been raised only once, and that was in 1957, despite constantly increasing costs of doing business. We have been able to offset increasing costs through increased efficiency and increased business, which has tripled since 1967.

ACCOUNTING

The accounting for life insurance companies is different than for other companies. The purpose of life insurance accounting ("statutory accounting"), as prescribed by the State regulatory authorities, is to determine the ability of a company to meet its policyholder obligations if the company were to be liquidated. Statutory accounting is not the "going business" concept of accounting used by corporations in general and by many insurance companies when reporting for other than regulatory purposes.

In statutory accounting, because of the assumption of liquidation, a company cannot defer any costs since it has no future. Thus, many items that would be deferred under generally accepted accounting procedures and charged off as premiums are collected (i.e., capitalized and amortized), must be charged off under statutory accounting in the year incurred. This is proper for liquidation accounting, but is not valid in making normal financial decisions about the profitability or the future of a company.

The statutory method of accounting, for example, shows that National Home "lost" \$17 million in 1971, whereas generally accepted methods of accounting show we earned a profit of \$13 million. The fact is that during 1971 we invested \$30 million in new business which will produce a minimum of \$200 million in future premiums. Statutory accounting treats this expenditure as a *total loss*, and thus reduces a \$13 million gain to a \$17 million loss.

We believe that companies should be required to comply with statutory accounting rules for regulatory purposes, but we also think that such accounting should not be used for purposes for which it was never intended.

The actuaries and managers of a company must look at results by year of issue. Combined figures for all years of issue as given by the Annual Statement are not significant in determining the reasonableness of premium charges, the profitability of the business, etc.

On the next four (4) charts, I have shown the ratio of claims to premiums for the three insurance companies owned by National Liberty Corporation. Chart 5 shows figures for National Home of New York. This company was formed in 1971 and commenced writing business on August 11, 1971. As we would expect the loss ratio in the first year will be low and is 28.2%. The ratio of claims to premiums will rise for this company as the business matures.

The policies issued in this company will have a cumulative payout of 60-65% of premiums for business issued above age 60 and a ratio of 60% for ages at issue below age 60 and qualify for an A+ rating in New York.

Chart 6 relates to National Home of Missouri. National Home of Missouri was purchased by our Group in 1969. During 1969 it earned \$11 million of

premium income and during 1971, \$52 million. The loss ratio as you can see is also low 45.3%, because the business is relatively new (largely written since 1969). The loss ratio, depending upon how much new business is written, will rise with each additional year of business added. Chart 7 is for National Liberty Life. This is the first insurance company owned by our Group. It started writing business in 1963. As a group, however, we have not written much mass-marketed, direct-response business in this company since the acquisition of National Home in 1969. Its business is therefore more mature than that of the other companies in the National Liberty Group. For National Liberty Life the loss ratio had increased to 62.6% by 1971. It will continue to rise with passing years.

Chart 8 shows the claims experience for the National Liberty Group combined. This shows how the loss ratio has increased over the years due to the maturing of business, despite our high proportion of new business.²

Chart 9 shows the experience during 1971 for the years of issue, 1960, 1965 and 1970 for all National Liberty companies combined. These figures show very clearly that as the business ages, the ratio of claims to premiums increases from 27.4% to 77.0%. To show what happens in an Annual Statement when all figures are combined, I have combined at the right hand side just the years 1970 and 1960. The large amount of premium on the new business as compared to the premiums on 1960 business causes the overall loss ratio to approximate the ratio for 1970 taken individually or 31.7%. The experience of both years is in line with what was anticipated in premium calculations. However, if you look at them combined, they would give the impression the company was paying out a very small part of its premium in claims. Let me say that if you were to look at the Annual Statement of life insurance companies and examine the results on individual life insurance, you would see precisely the same kind of results.

In substituting facts for impressions, the Annual Statement figures do not tell whether the contracts are in fact paying out little or much in claims. They do demonstrate clearly that the Annual Statement should not be used to determine the fairness of premium charges without analysis of the detailed underlying figures.

If our company were to pay out somewhere between 70-80% of premiums in claims as the figures show up in the Annual Statement (as is suggested by some), it would be necessary for us to request an increase in premiums quickly and frequently. If this were not done, the company would become insolvent in a matter of a few years for loss ratios would soon exceed 100%.

Our policies are fairly priced relative to both our competition and other forms of insurance, i.e., group and Blue Cross coverage.

I herewith hand to the Committee, and ask that it be included in the record of this hearing, a study by National Liberty of comparative costs and benefits of a representative number of companies that market the same kind of coverage. Some of these companies are engaged in mass marketing, while others distribute their products through agency organizations.

The study is a complex one making detailed comparisons of premiums and benefits, but this is the only way fair comparisons can be made of the various policies.

Our studies show that coverage granted by the National Liberty Group of companies in general gives more coverage at lower cost than any of the others. Among the principal reasons for this are the fact that National Liberty has been able to achieve substantial economies in its operations and has had confidence in its actuarial assumptions because of the broad base over which its costs and risks are spread. The company, in determining premium rates, assumes average rates of experience as to morbidity and mortality, and the more business a company writes the more probable it is that the company will have average experience. Similarly, the larger the base the greater the economies. We have been able to acquire a broad base, and consequently economies, by a concept approaching group insurance for the masses.

In this connection, we are of the view that the consumer would be benefited if more persons were eligible for some form of group coverage. However, our Company and others have been hindered from offering coverage on a group basis rather than on an individual basis by restrictive state laws. These restrictions are generally at the insistence of agency organizations which wish to protect what they assume, wrongly, we believe, to be their best interests.

² The reason for 1963 being as high as it is has to do with a reinsurance method of financing the company in its formative stages.

STANDARDIZATION OF POLICY FORMS

You have asked whether there should be standardization of contracts within the industry. I think this would be extremely unwise. Americans in general have expressed themselves emphatically that they do not wish to be treated as just another punch card. They are individuals and wish to be treated as such. It is a mistake to assume that you can put the specific health care needs of all Americans into a few standardized policies.

America is a large and diverse nation. Its people are individualists, their financial capacities are as dissimilar as are their faces. It would be extremely unwise for any small group of people to "decide" what the other members of our society may or may not have in hospital care or the insurance coverage to provide.

Just this year in Pennsylvania in another insurance field, the Commissioner of Insurance decided that everyone must have at least a \$100 deductible in his fire insurance policy. This is fine with me as an individual. I have always had such a deductible provision. However, there are a great number of people in Pennsylvania—people at the lower end of the economic scale—who cannot afford a loss of even \$100. They would prefer to pay the \$7 required for this benefit on a yearly basis. However, the Insurance Commissioner says "No"—and there is nothing we can do about it. It is a form of paternalism that was rejected by the people when practiced by management and should be rejected when practiced by Government.

If benefits are properly explained, there is no need to limit the number of policies or restrict the individual's ability to take care of his precise needs. We should attack the real problem which is proper disclosure, so that an individual can make an informed choice, and not try to legislate control of the number of different policy forms, provided, of course, that benefits offered by different policies offered meet standards of fundamental fairness and reasonableness.

REGULATION OF RATES

You have asked whether accident and health insurance rates should be regulated.

The Insurance Industry is already one of the most regulated industries in the United States, and this includes accident and health insurance rates. Regulation evolved in the various states for very valid reasons.

National Liberty is in favor of the effective and responsible regulation of insurance companies as being in the public interest. If present regulation by the states is not considered adequate, then additional guidelines should be established by Congress to increase the effectiveness of the existing state regulatory system rather than to add a Federal system. This would mean Federally mandated minimum standards to be administered by the states.

With particular respect to the regulation of premiums, there is currently sufficient control; especially in the area of individual policies. There is genuine rate competition and further, through State Departments' stipulations of acceptable loss ratios, rates are implicitly regulated.

ADVERTISING

Questions have been raised in this hearing whether advertising expenses incurred by mass merchandising insurance companies are too high and whether advertising content is deceptive.

Advertising is, of course, the sales tool—the agent, so to speak—for mass marketed insurance, and as one witness testified, health insurance must be sold. (See N.A. p. 152.) Our costs of distribution (including all advertising and marketing overhead) are only about half those incurred by agency oriented companies.

As to content, our advertising is subject to precise guidelines in every state and to review and prior approval by many. If state regulation is ineffective, review by the FTC is an available alternative.

Is the use of a testimonial fair or is it deceptive? Does the fact that the ads accentuate the positive make them misleading?

We believe that insurance advertising, like the advertising for other products, has a right to sell and be persuasive. I doubt that you will find an insurance agent coming to your door and saying, "I would like to sell you a policy, but I want to emphasize that it will not cover stays in the hospital beyond 30 days, the first 20 percent of all stays over 10 days, and, by the way, if you buy this policy from me I will get a commission equal to one-half of the first year's

premium plus a share of all renewal commissions"—and yet it has been suggested by some that insurance advertising should be loaded with warnings and negatives that to us are an insult to the intelligence of the consumer.

We live in a free enterprise system which is built on the right to sell a product positively and on its merits. We do that with our insurance products. We spell out the limitations and exclusions clearly so that the consumer who reads only the bold print will know what he is buying. As a matter of fact, because we sell through advertising, everything we say is in print and therefore misunderstanding is minimized. In all our ads the policyholder is given an opportunity to examine the policy, and if he is not satisfied he may return it to the company at no cost to him.

Do our ads exert undue pressure to buy? Let me ask you whether or not you could pressure a person into purchasing a product better in person or through a printed word? It is obvious that face to face selling has greater impact than the printed page or a TV commercial.

The final point I would like to make about our advertising is that in many states, including our home state of Pennsylvania, we have for years been submitting our ads for approval prior to their publication. We make changes suggested by the Departments and we have letters releasing the ads as being "not objectionable." It is puzzling to have our ads and commercials called "misleading" by the very individuals who approved them before use.

There will always be some who do not understand fully, of course, and we are anxious to cooperate with the Insurance Departments to improve our ads and thus reduce misunderstandings to a minimum. But we feel there has been an over-reaction on the part of a few who don't really understand the mass marketing and supplemental coverage concepts—and one of my purposes today is to explain them to you briefly.

PREPAID GROUP PLANS

Experience with prepaid group practice plans offers dramatic evidence that they can make a significant contribution to limiting health care costs by discouraging overutilization of health care facilities. (See e.g. N.T. pp. 347-349.) Under a prepaid group plan the doctor and his patient both have built-in incentives to use the most economical medical facilities and services, which are consistent with maintaining good health. Utilization of in-hospital care is reserved for those situations which require it. The provisions of many present health insurance contracts which schedule benefits according to treatment procedures may tempt some to overutilization of, for instance, surgical and x-ray services. The typical hospital indemnity policy offered by the National Liberty Group does not have a similar tendency because benefits are not a function of treatments performed.

We as a company have sought to encourage the Group practice of medicine in the Pennsylvania area, and we are presently cooperating with several groups which share our interest. However, it seems to me that this effort must be mounted nationwide and needs the involvement of the Federal Government.

Currently, the emphasis of insurance coverage is to take care of people after they have become ill. The new emphasis will have to be placed on keeping people well.

To me, the problem is not devising a new system of health care delivery, however, but rather how do you move from the present system to the proposed. This will not be accomplished until the medical profession, the hospitals, the insurance industry, the employers and the Government collectively agree to work together for the good of the consumer. The health care system can and must be monitored by itself and by cooperating institutions including the insurance industry.

MASS MERCHANDISING

Our particular approach to selling Supplemental coverage is through the medium of mass merchandising, i.e., through the newspapers, television, radio and the mails. Unlike other insurance our advertising expenses are the only marketing expenses incurred in connection with our supplemental hospital policies. We have no sales promotion or agents' commissions to pay.

Mass merchandising of insurance products is the trend of the future. Not only will our companies be selling accident and health insurance, but large amounts of auto and life insurance as well.

A company employing mass merchandising techniques can penetrate a market in a relatively short period of time, say a month; whereas, under traditional agency organization techniques, it would require decades to do the same job.

Not only can the job be done much more rapidly; but the fact is that the cost of distribution of a block of business is approximately half of that incurred by agency oriented companies.

There are less than 200,000 licensed agents selling individually marketed basic health insurance policies in the United States. Disproportionately few serve the rural, small town and inner-city markets. Large segments of our population are not, therefore, presently reachable through conventional insurance approaches and, even where agents are available, it appears that it has not been economically feasible to serve those in the lower income brackets on a person-to-person basis. Mass marketing techniques can and do service these areas and groups of people.

Dr. Herbert Denenberg, former Professor of Insurance at the Wharton School and now Insurance Commissioner of Pennsylvania, had the following to say in 1970 regarding mass merchandising:

"If the arguments now being urged against mass-marketed property and liability insurance *had prevailed in life and health insurance*, those lines of insurance would be much more primitive than they are. If wide-spread insurance coverage is assumed to be socially desirable, as a way to stabilize both individual and social life, the growth of mass marketed insurance is especially valuable, at least under appropriate circumstances, because it can bring the techniques of the 20th century—the savings of the assembly line—into a business that historically has had all the efficiency of the medieval artisan. Greater efficiency can bring not only economies but more effective spreading of risk, and consequently better and more nearly universal coverage, as well as other incidental advantages.

Yet despite what seem to be clear benefits of mass marketing in many situations, there has been constant opposition from special interest groups, as always clothing their arguments in the sanctity of the public interest." (emphasis supplied)

The number of people covered by some form of individual health insurance issued by the private sector was almost 46 million at the end of 1971—an increase of 21% in five years. Of this total, approximately 1.6 million were insured by the National Liberty Group of companies—more than triple the number covered five (5) years earlier. Thus, National Liberty, through new concepts in marketing methods that reach nearly everyone, has been able to increase the number of Americans covered by some form of health insurance at a much greater rate than the companies operating along more traditional lines. We believe that this evidence of the rapidly increasing acceptability of our product and of our mass marketing concepts demonstrates that we are rendering an important public service. And I want to reemphasize that our companies offer coverage to everyone regardless of age, race, color, sex, creed, condition of health or occupation. We do not try to take the "cream off the top."

I submit that traditionally marketed group and individual hospital expense reimbursement insurance, although vitally important, does not and cannot meet the needs of all citizens for adequate protection against the cost of catastrophic or serious accident and illness.

Supplemental Hospital Indemnity Insurance helps meet the many uncovered costs directly related to and incidental to health care, and services all segments of our society. The fact that this segment of the industry is growing so rapidly indicates that it is fulfilling an important need. There will remain many such uncovered costs regardless of what may come in the future under a National Health System.

We at National Liberty, as a leader in the mass-marketing field, feel that we are supplying an important supplemental coverage that cannot be supplied economically in any other way.

Let me again say I appreciate this opportunity to explain some of the factors of health insurance that give rise to questions in the mind of the public. I shall be most happy to try to answer any questions you may have.

Thank you.

JUNE 6, 1972.

NATIONAL HOME LIFE ASSURANCE COMPANY

COMPARATIVE RATES AND BENEFITS

The policies of the various companies in the health and accident field vary widely in coverage and thus can be evaluated only by a comparison of the principal premiums and benefits.

Our premiums at most age brackets are below the premiums of other direct marketing and agency structured insurers selling to the general public. Furthermore, our policies contain additional benefits which we believe, with the premium advantage, give our policyholders considerably better overall values than could be obtained from our principal competitors.

Those added values include level premium lifetime rates, as distinguished from limited term or "step" rates, dismemberment benefits, waiver of premiums, elimination of waiting periods and, at many age levels, higher and broader coverage and longer confinement periods than most comparable policies.

Compared with the values given by agency structured insurers, we are able to pass on economies resulting from our modernized mass marketing techniques.

Attached are schedules comparing our basic policies and those of 8 major agency companies and 3 major direct marketing companies in the accident and health field.

Policies of some of our competitors indicate premium advantages in a few age brackets. These advantages are more apparent than real, however, for in most cases the policies are not guaranteed renewable (and appropriately reserved), or the benefits are not comparable.

COMPARISON OF PREMIUMS AND BENEFITS OF HOSPITAL INDEMNITY POLICIES

NATIONAL HOME AND AGENCY COMPANIES BASIC PROVISIONS

	National Home NH10-669	Employer's Life Insurance Co. of America L 1952	Hartford Insurance Group No. 7219-5	Life Insurance Co. of Virginia 6320-4-67
Annual premiums:				
Single child: 0 to 18.....		\$22.16 ¹	Each child \$17.67 (to 20) 35.48.	\$9.23. ¹
All children:				
0 to 18.....	\$27			
19 to 24.....	\$48	\$50.53 ²	\$36.12	\$44.88. ²
25 to 29.....	\$48	\$50.53	\$39.97	\$49.15.
30 to 34.....	\$48	\$53.90	\$43.75	\$54.
35 to 39.....	\$48	\$64.03	\$47.92	\$58.86.
40 to 44.....	\$48	\$68.97	\$52.35	\$62.72.
45 to 49.....	\$55	\$77.25	\$57.23	\$66.58.
50 to 54.....	\$63.50	\$86.37	\$63.24	\$72.48.
55 to 59.....	\$69.50	\$96.86	\$72.21	\$78.37.
60 to 64.....	\$69.50			
65 to 69.....	\$69.50			
70 to 74.....	\$69.50			
75 to 79.....	\$83.50			
80 or over.....	\$97.50			
Maternity.....	\$13.50			
Hospital weekly benefit:				
Children.....	\$360 monthly	\$600 monthly ²	\$600 monthly	\$600 monthly. ²
Adults:				
16 to 24.....	\$600 monthly	do.	do.	Do.
65 and over.....	\$300 monthly ³	\$300 monthly	do.	Do.
Maternity (if husband and wife are covered).....	Yes.	Yes	No.	Yes.
Premium (level or step-rate).....	Level	Level	Level.	Level.
Aggregate limit per adult.....	None	52 weeks.	52 weeks.	52 weeks.
Policy underwritten (added waiver).....	No.	Not known	Not known	Not known.
Preexisting conditions covered after.....	2 years	do.	do.	Do.
Workmen's compensation exclusion.....	No.	Yes	Yes.	Yes.
Renewal agreement, renewal warranty, guaranteed renewable.....	Life	For life	To age 65 ⁴	To age 65.
Accident coverage begins.....	1st day	1st day	1st day	1st day.
Sickness coverage begins.....	do.	do.	do.	Do.
Additional restrictions.....				(⁵).

Footnotes at end of table.

COMPARISON OF PREMIUMS AND BENEFITS OF HOSPITAL INDEMNITY POLICIES—Continued

NATIONAL HOME AND AGENCY COMPANIES BASIC PROVISIONS—Continued

	National Home NH10-669	North American Co. for Life and Health PC1121	Bankers Life Casualty GR 755A	Continental Casualty P161377A
Annual premiums:				
Single child: 0 to 18.....		\$25.76 ¹	\$18.26 ¹	\$13.11.
All children:				
0 to 18.....	\$27.....			
17 to 24.....	\$48.....	\$40.85 ²	\$38.39 ²	\$29.33 ²
25 to 29.....	\$48.....	\$40.85.....	\$58.63.....	\$45.54.
30 to 34.....	\$48.....	\$40.85.....	\$69.30.....	\$49.60.
35 to 39.....	\$48.....	\$54.70.....	\$69.30.....	\$53.82.
40 to 44.....	\$48.....	\$54.70.....	\$79.20.....	\$60.72.
45 to 49.....	\$55.....	\$58.83.....	\$79.20.....	\$67.42.
50 to 54.....	\$63.50.....	\$65.68.....	\$89.87.....	\$75.90.
55 to 59.....	\$69.50.....	\$71.25.....	\$89.87.....	\$85.56.
60 to 64.....	\$69.50.....	\$78.59.....		
65 to 69.....	\$69.50.....	\$96.93.....		(Policy fee \$6 payable once).
70 to 74.....	\$69.50.....	\$124.62.....		
75 to 79.....	\$83.50.....			
80 or over.....	\$97.50.....			
Maternity.....	\$13.50.....			
Hospital weekly benefit:				
Children.....	\$360 monthly.....	\$600 monthly ⁶	\$600 monthly ²	\$600 monthly ²
Adults:				
16 to 64.....	\$600 monthly.....	do.....	do.....	Do.
65 and over.....	\$300 monthly ³	do.....	do.....	Do.
Maternity (if husband and wife are covered).....	Yes.....	No.....	Yes, not to ex- ceed \$50.	No.
Premium (level or step-rate).....	Level.....	Level.....	Level.....	Until age 65.
Aggregate limit per adult.....	None.....	52 weeks.....	Not known.....	52 weeks.
Policy underwritten (added waiver).....	No.....	Not known.....	do.....	Not known.
Preexisting conditions covered after.....	2 years.....	do.....	do.....	Do.
Workmen's compensation exclusion.....	No.....	Yes.....	Yes.....	Yes.
Renewal agreement, renewal warranty, guaran- teed renewable.....	Life.....	At option of company.	To age 65.....	To age 65.
Accident coverage begins.....	1st day.....	1st day.....	1st day.....	1st day.
Sickness coverage begins.....	do.....	do.....	do.....	Do.
Additional restrictions.....	None.....	6 months ⁵	6 months ⁶	6 months ⁶

COMPARISON OF PREMIUMS AND BENEFITS OF HOSPITAL INDEMNITY POLICIES—Continued

NATIONAL HOME AND AGENCY COMPANIES BASIC PROVISIONS—Continued

	National Home NH10 669	Reserve Life Insurance Co. GHR-5	Western & Southern Life Insurance Co. 315
Annual premiums:			
Single child: 0 to 18.....		\$14.80	\$30.67. ¹
All children:			
0 to 18.....	\$27		
17 to 24.....	\$48	\$37.13 ²	\$44.22. ²
25 to 29.....	\$48	\$59.46	\$51.46.
30 to 34.....	\$48	\$59.46	\$54.32.
35 to 39.....	\$48	\$59.46	\$61.19.
40 to 44.....	\$48	\$59.46	\$68.08.
45 to 49.....	\$55	\$60.43	\$73.03.
50 to 54.....	\$63.50	\$61.39	\$77.84.
55 to 59.....	\$69.50	\$61.39	
60 to 64.....	\$69.50	\$61.39	
65 to 69.....	\$69.50	\$91.55	
70 to 74.....	\$69.50	\$91.55	
75 to 79.....	\$83.50	\$132.28	
80 or over.....	\$97.50	(Policy fee \$6 payable once).	
Maternity.....	\$13.50		
Hospital weekly benefit:			
Children.....	\$360 monthly	\$600 monthly ²	\$600 monthly. ²
Adults:			
16 to 64.....	\$600 monthly	do.	Do.
65 and over.....	\$300 monthly ³	do.	Do.
Maternity (if husband and wife are covered).....	Yes	No	Yes.
Premium (level or step-rate).....	Level	Level	Level.
Aggregate limit per adult.....	None	100 days	26 weeks.
Policy underwritten (added waiver).....	No	Not known	Not known.
Preexisting conditions covered after.....	2 years	do.	Do.
Workmen's compensation exclusion.....	No	No	Yes.
Renewal agreement, renewal warranty, guaranteed renewable.....	Life	For life	To age 65.
Accident coverage begins.....	1st day	1st day	1st day.
Sickness coverage begins.....	do.	do.	Do.
Additional restrictions.....	None	6 month wait for TB, Cancer, diabetes, disease of heart, circulatory system and hernia.	6 month wait for hernia, hemorrhoids, adenoids, appendix, gall bladder, tonsils, female generative organs.

COMPARISON OF PREMIUMS AND BENEFITS OF HOSPITAL INDEMNITY POLICIES—Continued

NATIONAL HOME AND AGENCY COMPANIES BASIC PROVISIONS—Continued

	National Home, NH10-669	Union Fidelity Insurance Co., 1-525	Beneficial Stand- ard Life AL-833 medical
Annual premiums:			
All Children:			
0 to 18.....	\$20.50	16 to 39, \$43.50. ⁷	Individual plan, \$50. ⁷ Husband/ wife, \$75. 1 parent, \$53. All family, \$78.
17 to 24.....	\$38.50		
25 to 29.....	\$38.50		
30 to 34.....	\$38.50		
35 to 39.....	\$38.50		
40 to 44.....	\$38.50	40 to 49, \$54.	
45 to 49.....	\$42.50		
50 to 54.....	\$48.50		
55 to 59.....	\$55.50	50 to 69, \$66.50.	
60 to 64.....	\$55.50		
65 to 69.....	\$55.50		
70 to 74.....	\$55.50	70 and over \$88.50.	
75 to 79.....	\$62.50		
80 to 84.....	\$69.50		
85 and over.....	\$83.50		
Maternity.....	\$13.50	\$12.80.....	
Hospital weekly benefit:			
Children.....	\$360 monthly...	\$300 monthly...	\$100 monthly.
Adults:			
16 to 64.....	\$600 monthly...	Single/husband \$600, wife \$450.	Single/husband \$600 monthly, wife \$300 monthly.
65 and over.....	\$300 monthly ³ ...	\$300 ⁸	
Maternity (if H. and W. are covered).....	Yes.....	Yes.....	Yes.....
Premium (level or step-rate).....	Level.....	Level.....	Level.....
Aggregate limit per adult.....	None.....	240 weeks.....	156 weeks.
Policy underwritten (added waiver).....	No.....	No.....	Yes.....
Preexisting conditions covered after.....	2 years.....	2 years.....	2 years.
Workmen's compensation exclusion.....	No.....	No.....	No.....
Renewal agreement renewal warranty guaranteed renewable.....	Life.....	Life.....	To age 65.
Accident coverage begins.....	1st day.....	1st day.....	1st day.
Sickness coverage begins.....	4th day.....	4th day.....	4th day.
Additional restrictions.....	None.....	30 days and 6 months. ⁹	

¹ Average rate of male and female.² Normally sold on weekly benefit basis; has been adjusted to make equivalent to \$600 monthly basis.³ For 90 days, \$600 thereafter.⁴ Coverage terminates for spouse when reaching age 65.⁵ Six month waiting period for removal of tonsils, adenoids, conditions of female generative organs, hemorrhoids or hernia.⁶ Six month wait for hernia, TB, heart disease, hemorrhoids, tonsillitis, adenoids, appendicitis, disease of operative organs.⁷ Factor: Annual rate 10 times monthly.⁸ For 60 days, \$600 thereafter.⁹ Thirty day waiting period for new illnesses after effective date of policy; 6 month waiting period for TB, gallbladder disorder, diabetes, cancer, heart circulatory, hernia, sickness resulting in surgery, and diseases of generative organs.

COMPARISON OF PREMIUMS AND BENEFITS OF HOSPITAL INDEMNITY POLICIES

ADDITIONAL BENEFITS

National Home—All Plans

Nurse-At-Home-Benefits—\$400 month for home confinement following 5 consecutive days of hospitalization, but not to exceed the preceding hospital confinement.

Waiver of premium after 8 weeks in hospital.

Double benefits for husband and wife if confined simultaneously as a result of injury.

Dismemberment : \$2,000 maximum benefits.

Agency companies

Employer's Life Insurance Company of America.—Coverage for mental or nervous disorder not to exceed 4 weeks, then ½ benefits for 48 weeks.

Hartford Insurance Group.—None.

Life Insurance Company of Virginia.—None.

North America Company for Life and Health.—None.

Bankers Life & Casualty.—None.

Continental Casualty.—None.

Reserve Life Insurance Company.—None.

Western & Southern Life Insurance Company.—\$5000 Main Insured; Travel Accident Death Benefits: Principal Sum \$5000; \$1000 for other covered family members.

Direct marketing companies

Beneficial Standard Life.—Convalescent benefits for same period in hospital for which benefits were paid: Individual Husband \$300; Wife \$150, none for children.

Classified Insurance Corporation, Wisconsin.—None.

Union Fidelity Life Insurance Company.—None.

SUPPLEMENTAL HOSPITAL INSURANCE AND THE PUBLIC INTEREST

NATIONAL HOME LIFE ASSURANCE COMPANY (OF MISSOURI)

NATIONAL LIBERTY LIFE INSURANCE COMPANY (OF PENNSYLVANIA)

NATIONAL HOME ASSURANCE COMPANY OF NEW YORK

Subsidiaries of National Liberty Corporation

Ancient wisdom instructs us that good health is more precious than rubies. Universal good health is the objective of the medical sciences and access to adequate health care for everyone is a national goal. Mass marketed supplemental hospital insurance is important if we are to reach this goal. This paper will demonstrate how this newly developed private insurance product serves the public interest.

The valuable contributions of Buist M. Anderson, Esq., John H. Binning, Esq., John R. Maloney, Esq., Nicholas M. Monoco, Esq. and Prof. Alan Miles Ruben, who collaborated on the preparation of this position paper, are gratefully acknowledged.

THE NEED FOR SUPPLEMENTAL HOSPITAL INSURANCE PROTECTION

While 80 percent of the population under 65 has some private health insurance and Medicare provides some protection for 95 percent of the elderly, the inadequacy of benefits is generally recognized as a serious national problem. The fact is that most families are insufficiently protected against serious illness and accident.

As shown in the following graphs the cost of medical and hospital care in America has risen more rapidly than any other major sector of the economy. Significant but costly advances in medical technology coupled with severe and persistent inflation in the price of traditional services and facilities has put the cost of catastrophic and even major illnesses beyond the financial capacity of all but our wealthiest citizens.

PERCENTAGES OF VARIOUS CATEGORIES OF HEALTH CARE SERVICE
EXPENSE NOT COVERED BY INSURANCE OR PAID BY THE GOVERNMENT

HOSPITAL CARE	19%	DENTAL CARE	95%
SURGICAL SERVICES	21%	PRESCRIBED DRUGS	52%
IN-HOSPITAL VISITS	30%	NURSING HOME CARE	87%
X-RAY AND LAB	35%	PRIVATE DUTY	52%
OFFICE & HOME VISITS	57%	VISITING NURSE SERVICE	47%

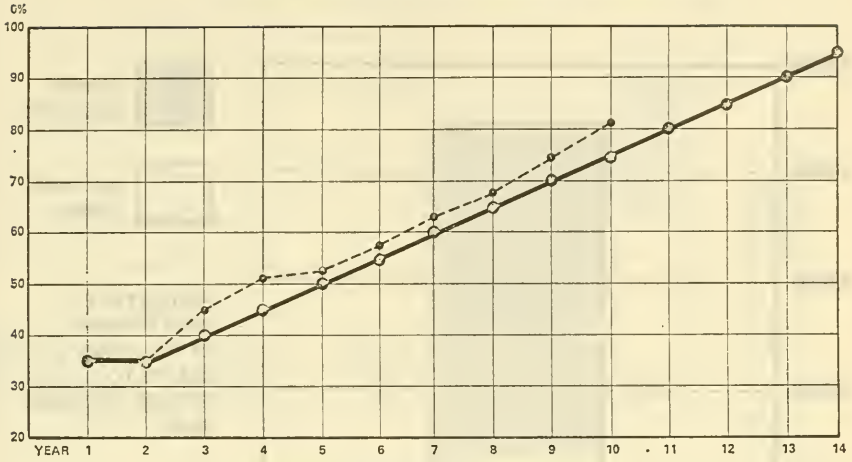
FROM "BASIC FACTS ON THE HEALTH INDUSTRY" PREPARED BY THE STAFF OF THE COMMITTEE ON
WAYS AND MEANS OF THE UNITED STATES HOUSE OF REPRESENTATIVES, FOR PERSONS UNDER 65
(PAGE 96)

Chart 2

	BLUE CROSS CROSS	GROUP INSURANCE	INDIVIDUALLY SOLD A & H CONTRACTS	SUPPLEMENTAL
COVERAGE	BASIC	BASIC	BASIC AND/OR SUPPLEMENTAL	SUPPLEMENTAL
BENEFIT	MEDICAL REIMBURSEMENT	MEDICAL REIMBURSEMENT	REIMBURSEMENT OR SUPPLEMENTAL	CASH PAYMENT
HOSPITAL STAY	LIMITED 30-60 DAYS	LIMITED 30-60 DAYS	LIMITED	UNLIMITED
HOW SOLD	PRIMARILY ON GROUP BASIS	GROUP BASIS	ONLY TO INDIVIDUALS	ONLY TO INDIVIDUALS
ADMINISTRATIVE EXPENSES	SHARED CARRIER AND EMPLOYER	SHARED CARRIER AND EMPLOYER	CARRIER	CARRIER ONLY
PREMIUM RATE CHANGES	SUBJECT TO YEARLY CHANGE	SUBJECT TO YEARLY CHANGE	SUBJECT TO CHANGE ON GUARANTEED RENEWABLE	GUARANTEED RENEWABLE
STATE TAXES	NO	YES	YES	YES
FEDERAL TAXES	NO	YES	YES	YES

Chart 3

NATIONAL LIBERTY GROUP ANTICIPATED CLAIMS RATIO
(SUPPLEMENTAL HOSPITAL INDEMNITY)



ACCUMULATED RESULT OF 60-65% OF PREMIUMS PAID OUT IN
CLAIMS QUALIFIES AS AN A+ RATING IN NEW YORK STATE
Red Dotted Line Indicates Actual Experience - All Years of Issue

Chart 4

NATIONAL HOME ASSURANCE COMPANY OF NEW YORK
RELATIONSHIP OF INCURRED CLAIMS TO EARNED PREMIUMS

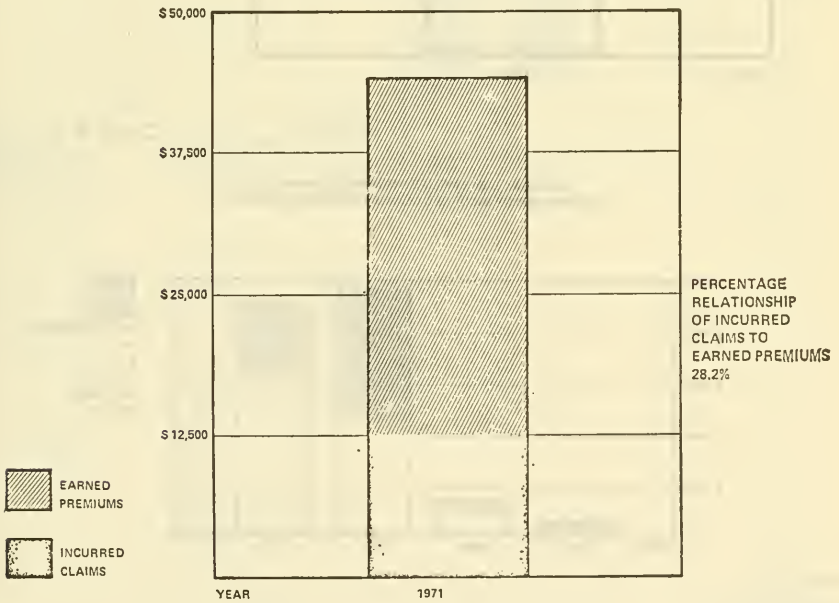


Chart 5

NATIONAL HOME LIFE ASSURANCE COMPANY
RELATIONSHIP OF INCURRED CLAIMS TO EARNED PREMIUMS

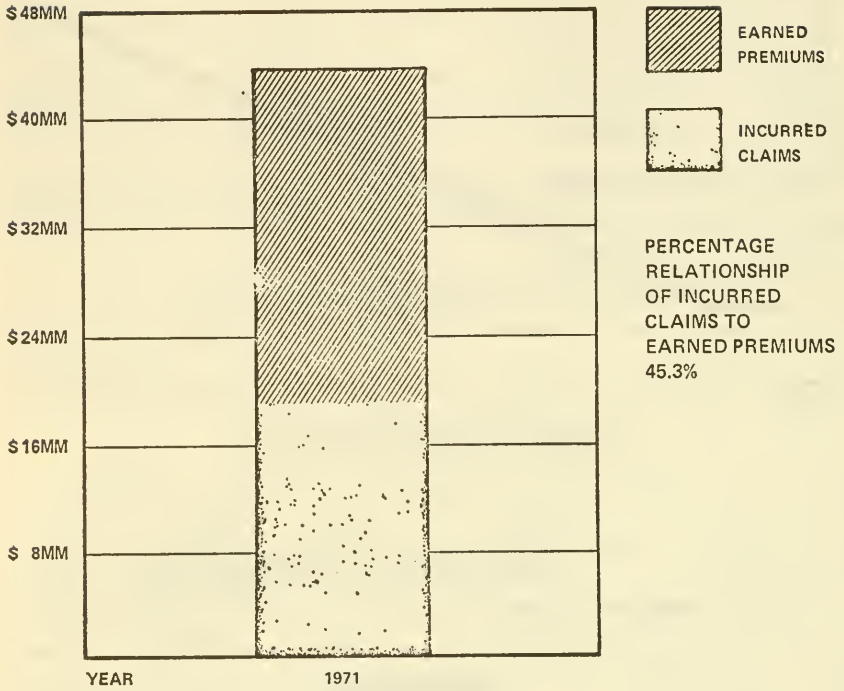
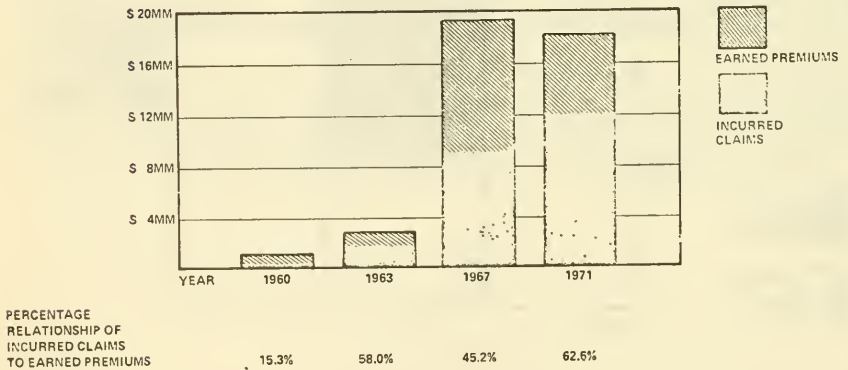


Chart '6

NATIONAL LIBERTY LIFE INSURANCE COMPANY
RELATIONSHIP OF INCURRED CLAIMS TO EARNED PREMIUMS



NATIONAL LIBERTY GROUP
RELATIONSHIP OF INCURRED CLAIMS TO EARNED PREMIUMS

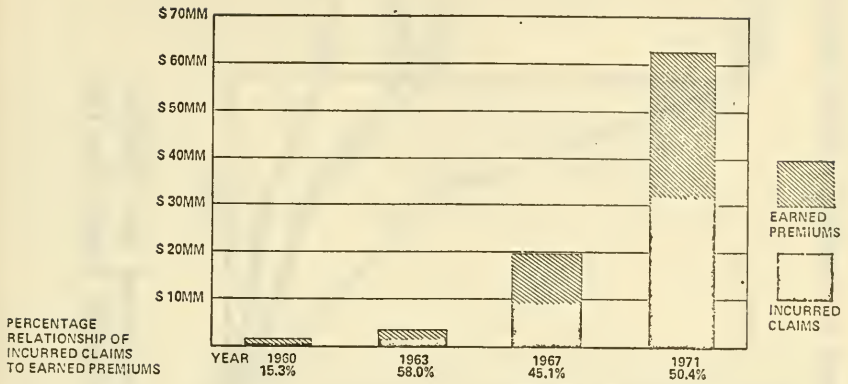


Chart 6

NATIONAL LIBERTY GROUP
RELATIONSHIP OF INCURRED CLAIMS TO EARNED PREMIUMS

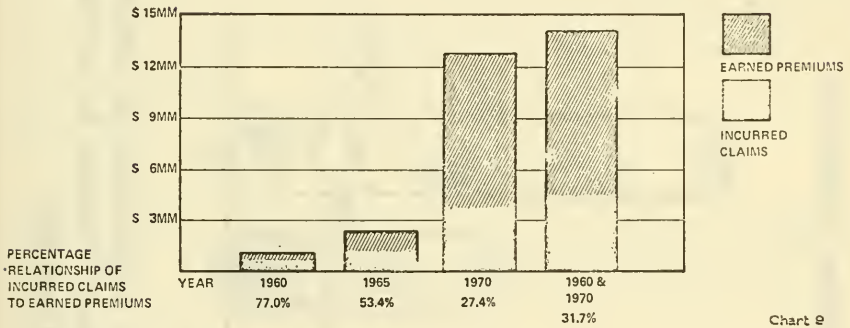
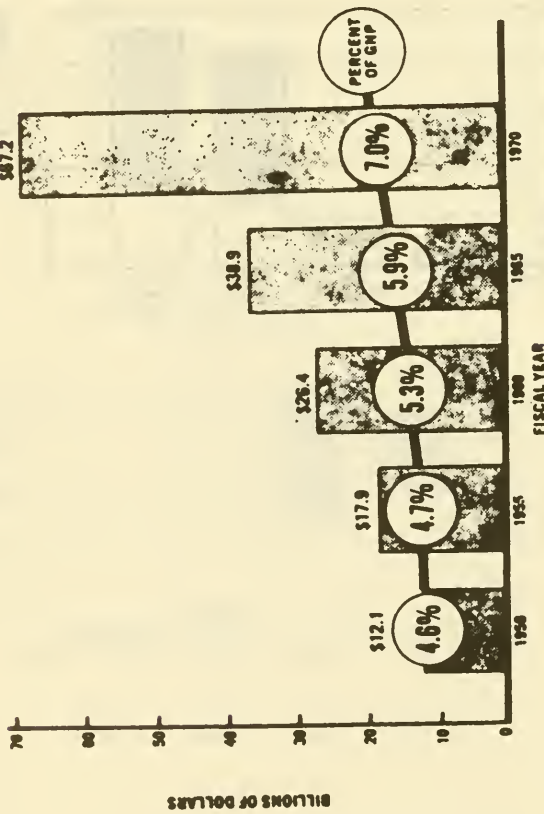
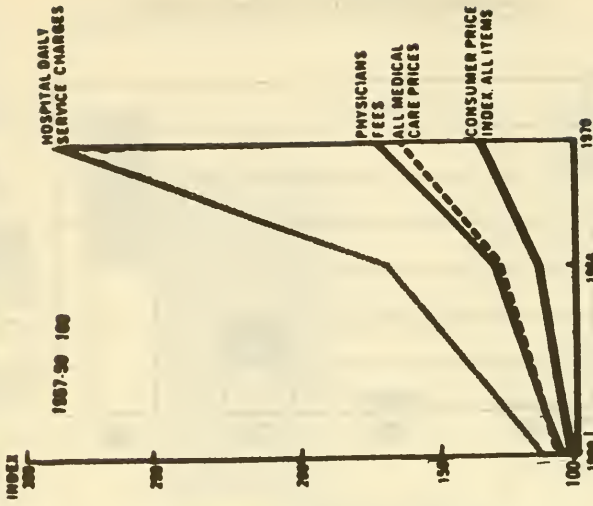


Chart 8

Growth in health expenditures, 1950-1970



Growth in medical prices, 1960-1970



Reproduced from Department of Health and Education and Welfare White Paper entitled "Towards a Comprehensive Health Policy for the 1970's." (Pages 21 and 22)

Obviously the shifting of the risk of loss due to serious illness from the individual to the group through the insurance principle is an imperative of our society. Yet, of the \$67 billion spent on health care in 1970 only \$16 billion (24 percent) was paid by insurance benefits while a staggering \$25 billion (40 percent) was paid by individuals directly out of current income or savings. The percentages of various categories of health care service expense not covered by insurance or paid by the government are given below:

	Percent		Percent
Hospital care.....	19	Dental care.....	95
Surgical services.....	21	Prescribed drugs.....	52
In-hospital visits.....	30	Nursing home care.....	87
X-ray and lab.....	35	Private duty nursing.....	52
Office and home visits.....	57	Visiting nurse service.....	47

Source: From "Basic Facts on the Health Industry" prepared by the staff of the Committee on Ways and Means of the United States House of Representatives. For persons under 65—1969. (Page 96)

The limited role of traditional forms of health insurance protection in meeting health care costs may be attributed to four key factors:

1. Limitations on eligibility for health insurance protection

Although the major portion of hospital expense reimbursement insurance is offered on a group plan, typically sponsored by an employer, some 25 percent of the working population is not covered by such plans. In addition, dependents of covered employees, the unemployed, the self-employed, migrant and seasonal workers and heads of households not in the labor market may not be eligible for group insurance protection.

Furthermore, policies written on an individual basis by agents generally require evidence of good health as shown by a detailed medical history and physical examination. Many members of the population cannot meet the relatively high "underwriting" standards set for the issuance of such insurance and the barriers to obtaining or maintaining protection on an individual basis increase with the age of the applicant.

Finally, membership in hospital and surgical benefit plans (Blue Cross and Blue Shield) may be similarly restricted by limiting severely the "open enrollment" periods.

2. High cost of individual health insurance policies.

The average annual cost of a basic hospital—surgical expense reimbursement policy is \$350. And, the cost rises as age increases, when family coverage is sought, when the scope of coverage is broadened and if medical history indicates a greater risk of illness. Accordingly, the lower an individual's income the less the likelihood of insurance protection. The percentage of persons having some form of hospital expense insurance, classified by level of income is given in the following schedule:

	Percent
Under \$3,000.....	36
\$3,000 to \$4,999.....	57
\$5,000 to \$6,999.....	79
\$7,000 to \$9,999.....	89
\$10,000 and over.....	92

Source: Basic facts on the Health Industry, *supra*. For persons under 65—1968. (Page 98)

3. Gaps, limitations and exclusions in coverage afforded by traditional hospital expense reimbursement insurance

Virtually all forms of hospital expense reimbursement policies contain internal limits of the amount of benefits which will be paid with respect to various categories of hospital charges. Most such policies provide no coverage at all for a number of common medical and hospital services. Even the so-called "major medical" insurance policies provide that the insured must pay the first \$500 of covered expense (the "deductible") and serve as "co-insurer" for up to 25 percent of covered charges incurred above the "deductible" limit. Finally, there are a multitude of additional expenses occasioned by accident and illness which are thought to be too peripheral to be covered under any form of hospital expense reimbursement policy. These include such items as cab fares to the hospital, non-prescription medications, loss of income when breadwinner is hospitalized

and household help when the housewife-mother is hospitalized. Taken together, these unreimbursed expenses associated with hospital confinement for illness or accidental injury may be overwhelming even for one with substantial insurance protection.

4. Limited access to agency marketed insurance

There are less than 200,000 licensed agents selling individually marketed basic health insurance policies in the United States. Disproportionately few serve the rural, small town and inner-city markets. Large segments of our population are not, therefore, presently reachable through conventional insurance approaches, and even where agents are available, it is just not economically feasible to serve those in the lower income brackets on a person-to-person basis.

As the foregoing analysis makes abundantly clear, traditionally marketed group and individual hospital expense reimbursement insurance does not and cannot meet the needs of all citizens for adequate protection against the cost of catastrophic or serious accident and illness.

THE RISE OF MASS MARKETED INDIVIDUAL HOSPITAL INDEMNITY INSURANCE

Hospital indemnity policies marketed through the mails and offering fixed cash benefits for each day the insured is confined to a hospital have been available for many years. However, it was not until the past decade that, spurred by rising medical costs and tightening underwriting standards, this form of insurance developed into a true mass marketed product and its volume became substantial. Today, over 50 percent of all new issues of individual hospital policies are of the mass marketed, supplemental indemnity type. Over 800 companies provide supplemental hospital indemnity coverage, but 90 percent of the business is written by only 12 carriers. Of these, the National Liberty group of companies is not only the pioneer, it is also the acknowledged industry leader.

Statistics are not available for comparison of the growth of mass marketed supplemental hospital insurance with the growth of health insurance generally, but the experience of the National Liberty Group would probably be fairly representative and a comparison of its increase in persons covered over the past five years with the total number of persons covered by insurance companies under individual and family policies is as follows:

	Total		National liberty group		
	Persons covered	Cumulative percent increase	Persons covered	Cumulative persons increase	Annual premiums
Year:					
1967.....	1 37,908,000	-----	511,900	-----	\$21,941,000
1968.....	1 39,709,000	5	578,400	13	25,210,000
1969.....	1 41,469,000	9	704,300	38	33,241,000
1970.....	1 43,480,000	15	1,057,000	107	44,684,000
1971.....	2 45,869,000	21	1,579,600	209	65,683,000

¹ From Health Insurance Institute "Source Book of Health Insurance Data," p. 16, as supplemented.

² Estimate.

THE CONCEPT OF MASS MARKETED SUPPLEMENTED HOSPITAL INDEMNITY INSURANCE

Initially insurance against the financial risk of hospitalization was written by agents on an individual basis. This kind of protection typically requires each application to be "underwritten" after consideration of a detailed medical history and often a medical examination. If an applicant is ill at the time, or has had an illness that is likely to recur, the application will be rejected, the illness will be excluded from the policy, or, if covered, a penalty premium will ordinarily be imposed, often so high as to make the price of the policy prohibitive. Such underwriting, of course, serves to avoid bringing into the insurance mechanism persons who present unreasonably high risk of loss. But the combined cost of agent solicitation expense and commission and individual underwriting is obviously very high and must be reflected in the premium charge.

At a later date, in response to the need to reduce the cost of vital hospital protection, the group insurance policy was developed. Relying upon a normal

distribution of risk inherent when a large number of individuals, associated together for reasons other than the purchase of insurance, are given coverage at one time, the group policy avoids the necessity for expensive individual underwriting. Costs are further reduced by elimination of the ordinary agent's commission on the acquisition of the business and through certain economies in policyholder servicing.

Mass marketed supplemental hospitalization insurance utilizes variations of the anti-selection and cost saving concepts of true group insurance to provide a kind of mini-group insurance policy that is as important to the structure of health insurance protection as the compact car is to the automotive market. As in the case of group insurance individual policy commissions are done away with and per policy acquisition costs are pared down through the solicitation of entire communities through mass media advertising and extensive mail campaigns. Members of the public are invited to respond directly to the solicitation by mailing an application form and the contract of insurance is completed by the return mailing of a policy by the insurer. Anti-selection protection against excessive participation by poor risks is provided by limiting the enrollment period and by excluding pre-existing conditions from coverage for two years after the policy is issued. These two techniques are explained in the following sections of this paper:

THE ENROLLMENT PERIOD

The urging of individuals to apply for coverage within a limited time span reduces the opportunities for the adverse selection which is invariably present when insurance is marketed on a voluntary basis. Such campaigns tend to draw a higher proportion of average or better risks and a correspondingly lower proportion of persons with impaired health who tend to seek out coverage. Enrollment deadlines are strictly enforced; late applications are rejected. Furthermore, so that the enrollment period for a product retains its vitality, it is not repeated in the same market for three months.

EXCLUSIONS OF PRE-EXISTING CONDITIONS

True group insurance contains a number of built-in safeguards against adverse selection. Thus, in the case of an employer sponsored plan, the persons covered are working and so presumably in average good health. Further, if all employees are not covered minimum participation standards are imposed to assure a representative and substantial sized group.

The mass marketed supplemental hospital policy does not have the advantage of these inherent protections against adverse selection. As an alternative the policy excludes pre-existing conditions from coverage for the first two years after issuance. In this respect the policy is similar to the traditional, individually underwritten contract where in some instances pre-existing conditions are "waivered" or excluded forever. But unlike the traditional individual contract, in such instances, the new supplemental policy becomes the equivalent of true group insurance after two years and all claims are thereafter paid regardless of any pre-existing health condition. The policy's "incontestable clause" prevents the pre-existing condition defense from being raised after the lapse of the two year period. And, unlike the individually underwritten contract, the supplemental policy may not be rescinded by the insurer within this two-year period on the ground that statements made in the application for the policy were false. Thus, the mass marketed supplemental hospital policy represents a compromise between individual medical underwriting and pure group anti-selection techniques, and is a significant advance in making a product very similar to true group insurance available to everyone.

The pre-existing condition exclusion is manifestly a necessary aspect of supplemental hospitalization insurance. Without such protection persons already ill would seek out the insurance and the cost of paying benefits to such policyholders would increase to prohibitive levels the premiums payable by the entire group. Insurance functions to protect the normally healthy person against the illness certain to occur. Nevertheless, National Liberty is currently testing various limitations upon the pre-existing condition exclusion. These experiments involve excluding only those pre-existing conditions that were actually treated or manifested within one or two years prior to the issuance of the policy. In addition, the Company is also testing a one year contestable period as part of its program to develop desirable alternative insurance products, although perhaps at high premium charges, based upon creditable actuarial experience.

Use of the limited enrollment period and pre-existing condition exclusion as anti-selection safeguards began on a controlled marketing basis in 1964. The results are now history. National Liberty has been able to offer, on a sound basis, more coverage to more people for the same premium, or the same coverage for less premium than is available under any conventional agency or mail order policy.

THE INDEMNITY FEATURE

Mass marketed supplemental hospitalization insurance provides flat indemnity amounts as benefits rather than reimbursement of hospital expenses incurred. The insured receives the benefit value of his policy upon proof of his confinement in the hospital and without proof of payment of specific expenses. The benefits are paid directly to the insured and the money may be used in his discretion to supplement other coverages or to meet expenses not subject to insurance protection. Benefits of \$20 to \$30 per day of hospitalization are paid by way of weekly or monthly indemnities. The payment of fixed sum benefits has three important advantages. It limits the Company's potential liability and thus permits it to relax customary anti-selection protections while keeping premiums relatively low. Second, it reduces the expense of claims administration since there are no itemized bills to be reviewed and verified. And, finally, since benefits are not tied to specific expenses maximum flexibility is obtained, and the policy can be used not only to meet costs attendant to serious illness not covered by other insurance but also to provide a measure of protection to the less advantaged who cannot afford more costly coverage.

THE PERMANENCE OF PROTECTION

Mass marketed supplemental hospitalization policies are usually guaranteed renewable for life or to age 75. Benefits are payable for extended periods ranging from two years to life. And, rates cannot be increased for an individual, regardless of his claim experience, except as part of a state-wide increase. (National Liberty has increased its rates only once in twelve years, and on only one policy form.)

THE PRICE AND THE MARKET

The premiums charged for mass marketed supplemental hospitalization insurance range between \$3.50 and \$10 a month for benefits of from \$500 to \$1,000 a month in the event of hospital confinement. The average premium is \$70 a year in contrast to the more than \$350 paid for the average basic hospital expense reimbursement policy. It may well be the only policy which a person of limited means can afford.

Furthermore, the insurance is made available to those who cannot be economically served by conventional face-to-face marketing techniques. Anyone who has a mailbox or access to a radio, newspaper or television also has access to supplemental hospital insurance.

The typical National Liberty policyholder profile bears out the fact that those who seek such insurance are by age, income and residence not likely to be candidates for traditional health insurance protection:

A "typical" National Liberty Group policyowner is fifty-five years of age, married and living with his spouse, employed by someone else in a white collar job, with a family income of \$7,500 and a high school education. He lives in a town with a population between 10,000 and 25,000 persons, owns the house in which he is living, has a conservative life style, and travels infrequently.

THE FUNCTION OF SUPPLEMENTAL HOSPITAL INSURANCE

Supplemental hospital insurance is paid when the need is greatest—when there has been hospitalization establishing the fact of serious illness. It is not intended to provide reimbursement for basic hospital expense. However, it is available not only to meet hospital costs left uncovered by other insurance, but also to defray the many related medical and peripheral costs, including loss of income, which medical reimbursement policies do not protect against.

MASS MARKETING SUPPLEMENTAL HOSPITALIZATION INSURANCE IN OPERATION

As we have seen, the exclusion of pre-existing conditions for a period of two years is the chief means of preventing adverse selection of serious proportions. Without this kind of provision in the policy, it would not be possible to offer quasi-group insurance to the entire public.

This exclusion is applicable during the two-year contestable period but only if the illness causing the loss was manifested or treated before the effective date of the policy. The majority of all claims submitted are processed solely upon the basis of the claim form. There are some cases, however, where the medical history is incomplete or uncertain for which additional information will be sought from the hospital, physician, and/or policyowner. In any event, under the National Liberty philosophy of claims administration, all reasonable doubts are resolved in favor of the policyowner.

Overall, for the year 1971, 87% of claims submitted (excluding duplicates, lapses, and no coverage) were paid. The remaining 13%, where the hospital records evidenced that the illness causing the hospitalization had indeed been treated or become manifest before the issuance of the policy, were rejected.

Where the information is complete, 50% of all claims are processed within 5 days, 85% within 7 days, and the balance within 10 days. Less than 2% involved extensive investigation requiring more than 90 days for processing. In such cases the delay was caused by the failure to receive requested information.

In a recent and typical week the National Liberty operations report disclosed the following time intervals for claims processing and performance of other administrative functions on behalf of policyowners:

[In days]

Function	Current week	4-week average	Standard
Claim processing.....	5.78	6.07	6.25
Correspondence.....	3.90	3.44	5.13
A. & H. policy issue.....	4.64	3.12	3.40
Life policy issue.....	4.03	4.57	5.40
Premium application.....	3.59	3.49	3.60

Note: This service was maintained during a period when we were placing new business on the books at the rate of more than 100,000 policies per month and paying claims at the rate of more than 15,000 per month.

CRITICISM AND RESPONSE

The innovation in product design, marketing and administration brought about by the mass marketed supplemental hospitalization policy is bound to be misunderstood by some and resisted by others. Progress is never without opponents. Four general criticisms have been leveled against mass marketed supplemental hospital insurance.

These involve the use of a "waiting period" before policyholders become eligible to receive benefits, the allegedly confusing variety of policies available, the absence of an agent to advise the policyholder, and the asserted maintenance of unreasonable low loss ratios. None of these asserted criticisms can withstand careful analysis.

WAITING PERIODS

Some supplemental hospital policies provide for exclusion periods so that the payment of benefits begins only after a specified number of days of hospitalization. These exclusions are similar to the familiar \$50 or \$100 deductible used in auto policies. Not only can small claims usually be borne by policyholders, but also, they involve disproportionately high administrative costs. The effect of such waiting periods is to eliminate small claims and thereby reduce premiums substantially. The waiting period thus preserves for the supplemental hospital policy its true concept—that of protecting against major loss rather than routine casualty.

The deductible concept has been specifically endorsed by the Department of Health, Education, and Welfare and many insurance departments on the ground that it helps to reduce the overwhelming pressures on scarce critical care centers. The patient with a minor illness which can be treated with or without hospital admission is less likely to insist on hospital care if he is not eligible to receive benefits for his short stay. Overcrowded critical care centers tend thereby to be reserved for people who really require the use of hospital facilities.

THE VARIETY OF POLICIES

The variety of mass marketed supplemental hospital policies available has been criticized on the grounds that comparison and choice is difficult. But, for from a fault, this is an outstanding advantage for it enables the consumer to choose the policy that best fits his requirements. Some may want to fill in the

gaps, deductions and exclusions in their basic coverages. But others, who cannot afford basic insurance at all, may want to provide at least some relief.

The alternative—standardization of policy form is not attractive. One proposal would do away with all supplemental coverages not approaching a level of benefit provided by basic plans. If the consumer cannot afford to buy all the coverage an insurance department thinks he needs, the proposal suggests he should buy nothing. But, something is usually better than nothing when it comes to health protection.

It would be a new and unfortunate role of government to tell the consumer what product he is permitted to have and deprive him of freedom of choice. To the contrary, the need is for the insurance industry to be the innovators in the mass marketing of insurance so as to broaden the base of coverage available in providing protection.

NEED FOR AN AGENT

It is sometimes stated that policyholders are confused by "mail order" insurance advertisements and policy provisions. The fact is that there is less chance for misunderstanding of mass marketed insurance than of insurance sold through personal solicitation.

Both the mass marketed policy and the attendant advertising are expressed in such clear, simple and concise terms that the average layman can understand exactly what he is buying. Since the advertising, which the buyer is free to retain, is spelled out in "black and white," there is no opportunity for the kind of misrepresentation, misunderstanding or ambiguity which can arise in "verbal" sales resulting from personal conversation.

Furthermore, it is in the best interests of the mass market insurer that its policies be concise and easily understood or otherwise they will not be salable, and if there is confusion in terminology, the subsequent policyholder service problem will inevitably increase administrative costs.

All policyholders are not "average," of course, and insurance is not a simple matter. Despite efforts to attain conciseness and clarity in policies and advertisements, some questions about them inevitably arise. National Liberty is meeting this challenge by installing extensive telephone systems manned by special operators who are trained to answer inquiries about its policies and who can be reached toll free, by dialing a special number. This number has already been supplied to all policyholders in the states contiguous to Pennsylvania and the system is being expanded to all other areas as rapidly as possible. With this system it is just as easy to talk to us as to a local agent, and through computers our operators have instant access to policyholder files so that inquiries usually can be answered in a matter of minutes. We are confident that this facility will go far in satisfying the need for policy information and advice.

The agent will always be needed in the sale of large, complex policies and to assist in family estate planning. But in the supplemental hospital policy market, National Liberty has demonstrated that there is no need for a personal visit by an agent to explain the simple concept involved.

LOSS RATIOS AND PROFIT MARGINS

National Liberty supplemental hospital insurance premiums are somewhat lower and its benefits somewhat greater than those of major competitors, whether operating through mass marketing or agency systems. Its overall loss ratios are well within accepted industry ranges and fully comply with "benchmarks" of the National Association of Insurance Commissioners. The overwhelming number of companies offering mass marketed supplemental hospital insurance also adhere to accepted industry standards.

Loss ratios in hospital indemnity insurance, as in life insurance, are low in the early years and increase as the business ages. Thus, the loss ratios on business written by National Liberty in 1959-1962 are now running in excess of 75%. Because we are growing rapidly, however, and a proportionately large amount of our business is new, our aggregate figures are below ultimate levels for aged business.

THE INDUSTRY ETHNIC

It has been said that there are over 800 companies now engaged in the mass marketing of supplemental hospital insurance. Most of these are entirely reputable and do an outstanding job in the public interest.

Perhaps, however, in an industry of this size, it is inevitable that there may be a few insurers who do not attach paramount importance to the interests of policyholders. Unfortunately, it is the questionable practices of a few rather than the sound operation of the many that receive the attention of the press and regulatory authorities. Exaggerated advertising, unfair and delayed claim processing and unreasonably low loss ratios cannot be defended. Companies guilty of such abuses are rightfully made the target of criticism and regulatory action. But it is unjust to stigmatize an industry on account of the practices of the marginal operator.

CONCLUSION

National Liberty has served the health insurance market for more than a decade. It has made available protection to families not customarily reached by conventional agency methods because its premiums are low. And even though the benefits, being supplemental in nature, do not provide complete coverage, to many policyholders they have meant the difference between misfortune and disaster.

To summarize, mass marketed supplemental hospitalization insurance has many advantages:

Availability.—Anyone can obtain it—including persons of modest means who cannot be economically served on a person-to-person basis under conventional agency methods.

Convenience.—No medical examinations are required, the policy being obtained by filling out a simple application form and sending it through the mails.

Simple to Understand.—The policies and explanatory advertising are concise and clear and are easily understood by the average person.

Less Expensive.—Mass marketing methods hold down solicitation costs, and savings are shared in the form of reduced premiums and increased benefits.

Better Insurance.—Benefits are based on general group insurance concepts that eliminate waivers of pre-existing conditions so that new illnesses are covered immediately and all illnesses—even pre-existing conditions—are covered after two years.

Mass marketed supplemental hospital insurance responds to a deeply felt need by a large segment of our population who are inadequately insured against the major perils of severe or long term accident or illness requiring hospitalization. It is the most effective way to reach great numbers of our citizens who are not within the market served by traditional agency solicitation. It offers prompt claims payment and a computerized policyholder service department able to respond immediately to policyholder questions received over the telephone. It represents health care protection designed entirely for the convenience of the policyholders.

These conclusions were confirmed by the National Association of Insurance Commissioners this past December when they adopted the Report of the Industry Advisory Committee on Health Insurance Advertising (1 Proceedings of the NAIC—, 1972), stating with respect to hospital indemnity coverage:

“This type of coverage is in the public interest and as supplemental coverage plays an important role in meeting the overall insurance needs of many individuals.”

National Liberty submits that mass marketed supplemental hospital insurance is a valuable component of the country's private accident and health insurance system and is in the public interest in these times of health care crisis.

STATEMENT OF ROBERT E. SLATER, PRESIDENT, NATIONAL LIBERTY CORP.

Mr. SLATER. Mr. Chairman, I have with me, on my left, Mr. William Patty, who is general counsel of the company.

On my right, Mr. Donald Kennedy, associate counsel.

In view of the fact that my prepared statement cannot be read in as short a time as desired, I have submitted the full text in writing, but I have reduced the material for this oral presentation.

Senator HART. Thank you very much for that. We will order the statement printed in the record in full. Thank you, sir.

Mr. SLATER. I appreciate very much the opportunity to appear before the subcommittee to help answer some of the questions being asked about health insurance coverage.

Ruskins has said that, "The work of science is to substitute facts for impressions and demonstrations for appearances."

I trust that my remarks today will help to clear up some of the misunderstanding currently existing about the health insurance field.

The costs of health care are rising and a significant portion of those costs—particularly for out-of-hospital services—are being borne directly by those who are suffering the most. The solution to these problems are difficult and require the cooperation of Government, consumers, the insurance industry, and the health care delivery system. One proposal that offers promise is prepaid group practice plans.

My position is explained in my written testimony. I would like, however, to devote the bulk of my time today to clearing up some of the misunderstanding that has been created by comparisons of loss ratios and benefit provisions.

First of all, however, let me outline briefly supplemental health hospital indemnity insurance which comprises the vast bulk of accident and health insurance written by the National Liberty Group.

Supplemental hospital indemnity insurance provides specific cash benefits to the policyholder for each day he is hospitalized, and it may also provide specific benefits for surgery, dismemberment, nursing services, et cetera.

The average premium per policy is approximately \$70 as compared to \$350 for an individual basic health insurance policy.

Benefits vary from \$20 to \$30 per day of hospitalization. It is not basic medical reimbursement coverage. It is supplemental insurance.

In fact, our studies show that more than 80 percent of our policyholders have other coverage such as Blue Cross or group insurance.

In other words, basic coverage does not cover all medical costs and individuals obtain additional coverage to help defray the cost of illness as well as those costs incidental to illness.

Supplemental hospital indemnity insurance is not intended to cover direct medical costs or the basic health insurance coverages, but rather the additional expenses not covered because of the gaps, exclusions and limitations of basic coverages, and those expenses incidental to medical costs.

The benefits are, however related to a stay in the hospital, since this indicates a serious illness and the need for money to meet the costs incidental to such serious illness.

Although basically a supplement to help fill in the gaps in basic coverage, our policies are purchased by some who cannot afford more costly basic coverages, and for such persons are obviously better than no coverage at all.

Already made a part of the record is a booklet entitled "Supplementary Health Insurance—Hospital Insurance and the Public Interest" which explains in considerable detail the principles underlying this newly developed private insurance product, how it is marketed and how it serves the public interest.

Now the subcommittee has expressed interest in clauses which limit benefits to the policyholder. The limitations are included in the

policies primarily to make it feasible to write the business and eliminate the adverse selection that would otherwise be created for the benefit of the few.

Insurance is primarily a sharing of risk of loss by a group of individuals to avoid the necessity that each individual assume his own losses. In order for any kind of voluntary program to be successful in a free society, it is necessary to include as much individual equity in the setting of premium rates as is possible.

People do not wish to pay more than a fair share of the total cost. This is true in almost everything. It is not peculiar to insurance.

Consequently, the cost of life and health insurance, for example, increases by age at the time of issue to take into consideration the fact that it is probable that losses will increase as a policyholder ages.

The same principles apply to health insurance. In order to prevent antiselection, different methods of underwriting are employed. Each has been devised for a particular form of coverage.

In Blue Cross and group insurance underwriting restrictions take a simple form. They typically require that 75 percent of the employees of a given employer join the plan and that the individual be at work when enrolled, that is, is in good enough health to be actively at work.

There is also a limited period of time in which an individual can enroll. In this way, since all in a particular age bracket pay the same premiums, they are assured of getting a fair share of the benefits since all will be in roughly the same state of health.

Under the traditional individual contract a medical examination, generally, has been required in order to avoid adverse selection; that is applications for coverage by persons already or chronically ill, since coverage of such persons would necessarily increase rates unfairly for those in normal good health.

The carrier underwrites each application, and will charge an extra premium, waiver out coverage for specific illnesses or deny coverage when the applicant has known medical problems.

Underwriting on a person by person basis is obviously a costly procedure.

Under supplemental hospital insurance distributed by mass marketing techniques, on the other hand, underwriting is eliminated through the use of the preexisting condition concept. No medical examination is required, and coverage for known medical conditions is not "waived" or "rated."

A preexisting condition that is manifest, or in some States, treated, will simply not be covered for a 2-year period.

Coverage, however, is granted to all who sign the application and pay the premiums. The premium varies only by age. There is no distinction based on race, color, creed, sex, occupation, or condition of health.

After the 2-year period, coverage is extended even to preexisting conditions as though the policyholder's health had not been impaired at the time of issue.

This simple protection against adverse selection, which is fully explained in the advertising copy and the enrollment form, makes possible a form of mass marketed group insurance similar to the group concept available to everyone, including many who could not be served economically on a person-to-person basis by agents.

Some look upon a preexisting conditions clause as a drawback. We believe this is because they have not taken the trouble to understand it. Actually, it permits insurance coverage to individuals who would not otherwise be eligible.

Senator HART. Mr. Slater, I wonder if as you give us your summary, it would be possible to refer to the page number in the basic full text that you are skipping. Can you do that?

Mr. KENNEDY. Mr. Chairman, we have copies of the oral testimony right over on the dais. We are now on page 5.

Senator HART. You have copies?

Mr. SLATER. Sorry. We sent up copies of the oral—

Senator HART. That's all right. Fine.

Mr. SLATER. Some look upon a preexisting conditions clause as a drawback. We believe this is because they have not taken the trouble to understand it. Actually, it permits insurance coverage to individuals who would not otherwise be eligible—a kind of group insurance for the masses—and we believe it is a truly important breakthrough in the insurance concepts.

National Liberty offers policies which provide for first-day coverage as well as 3- and 5-day waiting periods. The waiting period provisions are in response to announcements by many (including Commissioner Denenberg and the Department of Health, Education, and Welfare) that deductibles were favorable to assist in combating inflation and eliminating small claims.

Such provisions are in keeping with the traditional purpose of insurance—protection against the unusual (rather than the normally expected) loss. Policyholders may elect, however, to purchase first-day coverage.

Now several commentators have been quoted in the press and previous witnesses at these hearings have said that insurers pay out too little in benefits and in turn have exorbitant profits. The loss ratios quoted in the context of such stories and comments are usually derived from 1 year's business, often the experience of policies recently issued. As such, those statements, and the loss ratios on which they are based, are misleading.

In addition, a comparison of 1 year of Blue Cross and group insurance loss ratios with 1 year's loss ratio for individual health insurance policies is equally misleading.

Let me point out to you some of the major reasons for this, and some of the facts not mentioned at these hearings thus far.

Blue Cross and group insurance in the main are sold to the employer for the benefit of his employees. Presently rates are not guaranteed—premium rates are not guaranteed for any long period of time. In Philadelphia, for example, in the 1960's, Blue Cross had nine rate increases and as of April 1, 1972, was granted an additional 19½-percent increase by the Pennsylvania Insurance Department. The Price Commission has just recently approved rate increases in Group Health insurance for three major carriers on the order of 20 to 30 percent.

To put it in its simplest terms, group insurance is really on a cost-plus basis and can hardly be called insurance in the true sense of the word. The employer is even expected to make up any unusual losses that might occur.

In contrast, individually issued supplemental health insurance is guaranteed renewable and premium rates remain constant over long periods of time. In spite of increasing costs of operation, our companies, for example, have effected only one rate increase in 10 years.

The expenses of operation incurred by Blue Cross and group insurance carriers are entirely different from those incurred by carriers issuing individual contracts. In Blue Cross and group insurance many of the expenses of operation are not included in the figures you have seen.

Most obvious, of course, is the fact that Blue Cross does not pay any State or Federal taxes. Loss ratios for Blue Cross then are necessarily increased proportionately compared to those for commercial insurers which must pay taxes.

A good part of the administrative costs of handling claims, administrative detail, collection of premiums, and enrollment of new participants are paid by the employer and are not included in the carrier's costs. The overall cost is passed on to the consumer by the employer even though it does not show up in the carrier's figures.

If these costs were included in the carriers' costs, loss ratios would decline substantially. All of these are borne by the carriers which issue individual supplemental health insurance, and thus their reported loss ratios are proportionately decreased.

The experience of large Blue Cross and group insurance cases obscures the claim payments figures on small group cases. The figures reported by group carriers are for all the business written by the companies, and the experience for large cases (because they account for the bulk of premiums) swallow up the results for small cases.

For small group cases, it is my judgment that expense ratios and claim ratios approximate what we anticipate the cumulative ratios will be for supplemental indemnity insurance marketed by mass merchandising techniques.

Large group health insurance cases are often sold in conjunction with group life insurance, and premium rates are determined based on projections of combined loss ratios anticipated for the life and the health insurance contracts. Thus, it is possible that loss ratios for some group accident and health insurance contracts could exceed 100 percent, because the loss from the group accident and health contract could be recovered by the group life insurance contract and sold simultaneously.

Now, I am not critical of these practices, but I do believe if comparisons are being made, these factors should be taken into consideration. I am mindful of what former dean of the Wharton School, Dr. Kulp, said, and I quote.

The materials available for analysis, particularly loss and underwriting ratios are, in the hands of experts, of very little help. The moral is not that loss and underwriting ratios are to be ignored, but that the greatest caution is required in translating them into standards for judging the adequacy and the reasonableness of premiums.

Now, let me turn to the charts we have prepared relating to the National Liberty Group of companies.

First of all there is a chart showing expected morbidity rates, and those that have been actually experienced.

This chart shows that the loss ratios that morbidity experience indicates will occur and are assumed in premium calculations. The ex-

pected loss ratios are 35 percent in the first and second year, and increases 5 percent a year thereafter.

Taking all policy years into consideration, premiums collected and claims paid for a given year of issue, it is anticipated that the company will pay out over the life of the business in claims to the policyholders 55 to 60 percent of all premiums.

These anticipated loss ratios comply with the regulations of State insurance departments imposed in connection with policy approvals.

In dotted lines on the same chart is the actual experience of the National Liberty Group of companies. We have taken all claim experience by year of issue for the National Liberty companies since 1960, and combined them to get the overall result.

Because of the peculiarities of a deviated premium for the first month of issue in some States, the first and second year experience has been combined. The first and second years' experience is just slightly below the expected results; whereas, for all other years, the actual experience has exceeded the anticipated results.

Now, the accounting for life insurance companies is different than for other companies. The purpose of life insurance accounting, that is statutory accounting, as prescribed by the State regulatory authorities, is to determine the ability of a company to meet its policyholder obligations if the company were to be liquidated.

Statutory accounting is not the "going business" concept of accounting used by corporations in general and by many insurance companies when reporting for other than regulatory purposes.

In statutory accounting, rather, because of the assumption of liquidations, a company cannot defer any costs since it has no future. Thus, many items that would be deferred under generally accepted accounting procedures and charged off as premiums are collected (that is, capitalized and amortized), must be charged off under statutory accounting in the year incurred.

This is proper for liquidation accounting, but is not valid in making normal financial decisions about the profitability of the future of a company.

The statutory method of accounting, for example, shows that National Home "lost" \$17 million in 1971, whereas generally accepted methods of accounting show we earned a profit of \$13 million.

The fact is that during 1971 we invested \$30 million in new business which will produce a minimum of \$200 million in future premiums. Statutory accounting treats this expenditure as a total loss, and thus reduces a \$13 million gain to a \$17 million loss.

We believe that companies should be required to comply with statutory accounting rules for regulatory purposes, but we also think that such accounting should not be used for purposes for which it was never intended.

The actuaries and managers of a company must look at results by year of issue. Combined figures for all years of issue as given by the annual statement are not significant in determining the reasonableness of premium charges, the profitability of the business, et cetera.

On the next four charts, I will show the ratio of claims to premiums for the three insurance companies owned by National Liberty Corp. Chart 5 shows figures for National Home of New York.

This company was formed in 1971 and commenced writing business on August 11, 1971.

As we would expect, the loss ratio in the first year will be low and is 28.2 percent. The ratio of claims to premiums will rise for this company as the business matures. The policies issued in this company will have a cumulative payout of 60 to 65 percent of premiums for business issued above age 60, and a ratio of 60 percent for ages at issue below age 60 and quality for an A-plus rating in New York.

Chart 6 relates to the National Home of Missouri. National Home of Missouri was purchased by our group in 1969. During 1969 it earned \$11 million of premium income and during 1971, \$52 million.

The loss ratio, as you can see, is also low, 45.2 percent, because the business is relatively new. The loss ratio, depending upon how much business is written, will rise with each additional year of business added.

Chart 7 is for the National Liberty Life. This is the first insurance company owned by our group. It started writing business in 1963.

As a group, however, we have not written much mass-marketing, direct-response business in this company since the acquisition of National Home in 1969.

Its business is therefore more mature than that of the other companies in the National Liberty Group. For National Liberty Life, the loss ratio had increased to 62.6 percent by 1971. It will continue to rise with passing years.

Chart 8 shows the claims experience for the National Liberty Group combined. This shows how the loss ratio has increased over the years due to the maturing of business, despite our high proportion of new business.

Now chart 9 shows the experience during 1971 for the years of issue, 1960, 1965, and 1970, for all National Liberty companies combined. These figures show very clearly that as the business ages, the ratio of claims to premiums increases from 24.7 to 77 percent.

To show what happens in an annual statement when all figures are combined, I have combined at the right hand side just the years 1970 and 1960.

The large amount of premium on the new business as compared to the premiums on 1960 business causes the overall loss ratio to approximate the ratio for 1970 taken individually or 31.7 percent.

The experience of both years is in line with what was anticipated in the premium calculations. However, if you look at them combined, they would give the impression the company was paying out a very small part of its premiums in claims.

Let me say that if you were to look at the annual statement of life insurance companies and examine the results of individual life insurance, you would see precisely the same kind of results.

In substituting facts for impressions, the annual statement figures do not tell whether the contracts are in fact paying out little or much in claims. They do demonstrate clearly that the annual statement should not be used to determine the fairness of premium charges without analysis of the detailed underlying figures.

If our company were to pay out somewhere between 70 and 80 percent of the premiums in claims as the figures show up in the an-

nual statement (as is suggested by some), it would be necessary for us to request an increase in premiums quickly and frequently. If this were not done, the company would become insolvent in a matter of a few years, for loss ratios would soon exceed 100 percent.

Now, our particular approach to selling supplemental coverage is through the medium of mass merchandising; that is through the newspapers, television, radio, and the mails. Unlike other insurance, our advertising expenses are the only marketing expenses incurred in connection with our supplemental health policies.

We have no sales promotion or agents' commissions to pay.

In my written submissions, I have gone into some detail in describing our mass merchandising approach to marketing insurance products. Let me summarize my conclusions.

Mass merchandising of insurance products is the trend of the future. Not only will our companies be selling accident and health insurance, but large amounts of auto and life insurance as well.

A company employing mass merchandising techniques can penetrate a market in a relatively short period of time, say a month; whereas, under traditional agency organization techniques, it would require decades to do the same job.

Not only can the job be done much more rapidly, but the fact is that the cost of distribution of a block of business is approximately half of that incurred by agency oriented companies.

Mass merchandising techniques can and do service the rural, small town, and inner-city markets not presently served adequately by conventional agency methods.

The acceptability of our products and mass marketing concepts are rapidly increasing. The number of people covered by some form of individual health insurance issued by the private sector was almost 46 million at the end of 1971—an increase of 21 percent in 5 years.

Of this total, approximately 1.6 million were insured by the National Liberty Group of companies—more than triple the number covered 5 years earlier.

Our companies offer mass merchandised supplemental indemnity coverage to everyone regardless of age, race, color, sex, creed, condition of health, or occupation. We do not try to take the "cream off the top."

I submit that traditionally marketed group and individual hospital expense reimbursement insurance, although vitally important, does not and cannot meet the needs of all citizens for adequate protection against the cost of catastrophic or serious accident and illness.

Supplemental health insurance meets the many uncovered costs directly related to and incidental to health care, and services all segments of our society. The fact that this segment of the industry is growing so rapidly indicates that it is fulfilling an important need. There will remain many such uncovered costs regardless of what may come in the future under a national health system.

We at National Liberty, as a leader in the mass-marketing field, feel that we are supplying an important supplemental coverage that cannot be supplied economically in any other way.

Let me again say I appreciate this opportunity to explain some of the factors of health insurance that give rise to questions in the mind of the public. I shall be happy to try to answer any questions you may have.

Thank you.

Senator HART. Thank you very much, Mr. Slater. We thank you for the cooperation you have given the committee in providing material and information, and so on.

Mr. SLATER. I am only too happy to do so.

Senator HART. Based on some of that documentation, Mr. O'Leary and Mr. Sharp have developed some questions that I think will qualify and underline our concern.

Mr. O'Leary?

Mr. O'LEARY. Thank you, Mr. Chairman.

Mr. Slater. I would like to run through with you a series of questions in regard to a profile of the types of policies which National Liberty sells.

This information is taken, to some extent, from your policyholders survey.

Quoting from portions of it, "National Liberty's current appeal is to those with a low family income. Most policy owners have family incomes of less than \$8,000 because of a large number of retired policy owners."

"Most all low-income policy owners are over 55 years of age; twice as many females in this classification as males."

Quoting a little further, "Most policy owners have only a high school education or less. Thirty-three percent have completed some college or more. This is especially true in the younger and older age groups."

From our reading of this survey, it would appear that the majority of the present policy owners are female, elderly individuals, with a low family income and a high school education, or less. Is that generally correct?

Mr. SLATER. Well, if you take something on the order of \$7,500 of the average income as low, then the answer is yes.

Mr. O'LEARY. Quoting a little further, "Males are difficult to maintain as policy owners over a period of time. Our marketing must accentuate the importance of not leaving their families without protection. Ideas such as 'who will pay the bills when you are in the hospitals?' should be conveyed."

Quoting a little further, "A large proportion of policy owners in the U.S. population are widowed, divorced, and separated." This indicates appeal to those who are not immediately supported by a spouse.

"Your ad copy should emphasize the necessity of coverage especially when not immediately supported by a spouse."

Would it be a fair statement to say that your marketing practices are aimed in playing upon the fears of elderly people in this regard?

Mr. SLATER. I don't think that's a fair statement at all. I think what you were reading is a marketing survey that has been made by some of the marketing people. But I don't think that necessarily is what goes into the advertising copy.

If you look at our advertising copy, I don't think you will find that there are any scare headlines, or anything else. We try to be very explicit in what the provisions are, what coverage is granted, and try to do a fair job.

Remember that every policyholder has at least 10 days to look at the policy and all the material in connection with it. If he doesn't like it, he can return it and have any moneys he may have paid up to that time refunded in full.

Mr. O'LEARY. You were kind enough to supply us with a number of different policies. Looking now at NH-10-669, I believe this is the policy which is marketed in St. Louis, in Missouri, under the title of National Home Life Insurance Company, Old Line Legal Reserve Company, St. Louis, Mo.

Underneath that it says, "Extra cash hospitalization indemnity plan."

What I am interested in is the preexisting condition clause which is about halfway down the page.

It reads as follows:

After two years from the date this policy becomes effective for a covered member, hospital confinement commencing thereafter while the policy is in force for such covered member, and as a result of any such condition for which such covered member was medically treated, or advised prior to the effective date, shall be covered hereunder.

Precisely what does that mean?

Mr. SLATER. I tried to explain that in my oral testimony but I am afraid, Mr. O'Leary, I didn't get across that particular idea.

This is the only underwriting condition that we have in our contracts. We take everyone who signs the enrollment form and pays the premium.

We have a stipulation that if there is a preexisting condition existing at the time the policy is issued, that we will not pay a claim for a 2-year period. So that for instance, if you had been treated for a heart condition, and you take out one of our policies, for the first 2 years you will not be covered for any heart condition if you go into the hospital.

You would be covered for anything else.

Now, I might say for your information, that just yesterday we issued a public release where we have limited excluded the preexisting conditions to be manifest or treated within 12 months prior to the issuance of the policy.

Now this is the only underwriting provision that we have. Now, other contracts, individual contracts, will waive that particular illness out. They will decline coverage, or they will charge you a rated premium.

We do not do that, and it makes for a very simple underwriting approach.

Mr. O'LEARY. As I understand it, that clause means that if I have a condition, I am not covered until 2 years has run from the effective date of the policy.

Mr. SLATER. Well, our particular policy says that there has to be some manifestation of that illness, or it must be treated within 12 months prior to the issuance of that policy for the exclusion to be effective.

In other words, if you had a heart attack 10 years ago, and you had no treatment by a doctor in the 1 year preceding the issuance of the policy, we would cover you for that particular ailment.

Mr. CHUMBRIS. Will counsel yield? I believe that on page 7 of your primary statement, your larger statement, you give the example of Miss Mary Lynn Fletcher, who appeared before the subcommittee.

That even under her condition, after 2 years she has had that policy, even with her infantile paralysis that has crippled her for most of her

life, she would be able to get full benefits like anyone else after a 2-year period. *

Mr. SLATER. For that particular ailment that she had. That is correct.

We think that this is, in fact, a breakthrough, although a lot of people think that it is a detriment.

Mr. O'LEARY. Mr. Slater, are you a lawyer?

Mr. SLATER. No. I happen to be one of those who are known as an actuary. Mr. Patty is a lawyer.

Mr. O'LEARY. Well, my question is do you find that language clear when you read that preexisting condition clause? I have reread it a number of times, and I must confess that it doesn't seem to leap out at me that I am not covered for 2 years.

Well, I guess the thrust of my question is do you really think the people to whom you market this policy understand that?

Mr. PATTY. I think the statement in the policy could be improved, but you must understand now that this language has to be approved by every State in which we operate, and this language is the language of the States—that is what they have, in fact, required of us, and approved.

We do state this proposition more simply in layman's language in the advertising material. As Mr. Slater stated, we are going to improve on this further.

Senator HART. Mr. Slater, you emphasize, I think in your reply to a question, that you tried to be very explicit in your advertising.

And you then noted that a policyholder would have 10 days to study his policy. Thereby, you require making doubly sure that he would understand what he was getting.

But I have been listening here while trying to read other chores. I am a lawyer, and I cannot understand actuaries. Maybe the reason that you understand this is because you are an actuary.

But let me read it again.

After two years from the date this policy becomes effective for a covered member, hospital confinement commencing thereafter while this policy is in force for such covered member, and as a result of any condition for which covered member was medically treated or advised prior to the effective date, shall be covered hereunder.

Mr. SLATER. Senator Hart, may I add for your information that in the so-called fulfillment kit that is sent to the policyholder with the policy, the premium notice, and other things, there is a full explanation made of this particular clause.

Senator HART. Do we have that?

Mr. SLATER. You may not have it, but we do have a very full explanation with examples and everything else so that the policyholder can understand what this means.

The material is in the process of being revised because we have limited the exclusion for preexisting conditions to those treated or manifest for 12 months prior to issuance, and we will be very glad to send you copies of that.

I think you will find in reading that over, although you may not understand this legalese that the insurance departments require, I think that the written explanation does explain it very precisely.

Senator HART. Well, I would ask that the excerpts from that docu-

ment, which is sent to the policyholder, be printed at this point in the record.

Mr. SLATER. We don't have it here, though.

Senator HART. No, but we will hold the record for it. Second, you say that that would make more clear the language which I have just read which is required or approved by the several State insurance departments.

But I would question whether an insurance department in approving that contract language was really doing its very best to insure a contract that was understandable.

That really isn't too much of a shock.

Mr. SLATER. I think that we can clarify that. Let me read to you the advertising which I think makes clear in the information.

It says:

Any sickness or injury which existed prior or before the policy went into effect, these pre-existing conditions are covered after the policy has been in force two years.

Now that is, I think, much more explicit than what you are talking about, and this is listed under "These are the only exclusions."

Senator HART. Anything that is wrong with you now will not be paid for 2 years. That's the point.

Mr. SLATER. That is in effect what this now says.

Senator HART. I would not expect you to put it as bluntly as I have just summarized. You can really do better than the way it is put though, wouldn't you agree?

Mr. SLATER. I think your comment is well taken, and we will get that changed.

Mr. CHUMBRIS. Mr. Chairman, will counsel yield for just another moment.

Just a moment ago, Mr. O'Leary asked you a question about who the people are that constitute the largest proportion of the buyers of your supplemental policy. You indicated that they were people around the \$7,500 class.

I was just wondering if that isn't perhaps the most important people who probably want supplemental insurance. Someone who is making \$35,000 a year, he is satisfied with his primary policy. If he has to pay over and above what the policy covers, it wouldn't hurt him too much.

But if it happens to be a widow, or a divorcee, and she has a 10-year-old child, she probably could not stand \$15 a day extra that the insurance policy does not cover. She is more apt to worry about spending maybe \$40 a year to get back \$8,300 that you would if you joined the Federal Bar Association supplemental plan.

Mr. SLATER. I think that is correct, sir.

Mr. CHUMBRIS. Because they pay \$25 a day for 365, if you happen to be in the hospital 365 days. So for \$40, if you are in that group from 35 to 44, you are getting \$8,300.

Mr. SLATER. That is correct. The people at the lower end of the economic scale want more complete coverage than those who are at the higher end.

Mr. CHUMBRIS. Isn't it true that most people buy insurance because they are scared? Whether it is automobile insurance, fire insurance for the house, life insurance, or whatever the case may be.

Some of them out of fear—if they are making \$100,000 a year, or whether you are making \$7,500 a year.

Mr. SLATER. Insurance is a sharing of losses. People do not feel that they can sustain that particular loss themselves, and consequently they buy insurance to spread the risk.

Mr. O'LEARY. Mr. Slater, I note that with respect to the policy that is marketed in New York, the preexisting condition clause is worded considerably different.

I will read it.

Pre-existing conditions. Hospital confinement commencing after the effective date of this policy shall be covered unless the illness (sickness, disease, or physical condition) causing the confinement is medically advised or manifested in one year immediately prior to the effective date; such limitation will not be invoked, however, unless the illness was the kind or of such severity that the company in its accordance with its underwriting standards applicable to the underwritten form, or to like or similar insurance, would decline such insurance and require a policy modification, use of a rider.

I take it the New York State Insurance Commissioner found the clause to which I made reference earlier less than satisfactory and preferred this one, or what?

Mr. SLATER. They have different rules in a lot of the States. New York has a different rule, and New Jersey has another different one.

But I mentioned, Mr. O'Leary, that our company has, as of yesterday, adopted the New York rule for all of the policies, except in New Jersey, which is slightly different.

We are making it retroactive to those policies that are already on the books.

Mr. O'LEARY. But why the 1-year difference in New York as opposed to the other?

Mr. SLATER. Well, I guess you could, Mr. O'Leary—let us assume that you have some kind of a heart condition, and had it when you were born. I don't know your age, but let us assume that you are now 40 years of age, and you went to the hospital.

Without some limitation of the time period prior to the time of the issuance of the policies during which the exclusion could be invoked, you could go back and claim, if you desired, that thing that happened 40 years ago.

Now we have never done anything like that. But in theory, or legally, if we have that clause in there, we could make that kind of a claim. New York says, "Stop it. We will put a 1-year limitation period. You must be treated for the ailment, or whatever it is must be manifest within the 12 months preceding the issuance of that policy, of the condition will not be excluded."

Now, we said we think that is very valid reasoning in that it is good enough for the underwriting restrictions that we want, and we have adopted for all our business.

Now New Jersey makes the further distinction that you must in fact have been treated in that 12-month period. It could be manifest, but the fact that you have got to be treated in addition to that, we are not too happy with that particular provision.

Mr. O'LEARY. You agree that New York is generally thought to be a tightly regulated State as far as insurance is concerned?

Mr. SLATER. Yes.

Mr. O'LEARY. And the State regulation does vary considerably from State to State?

Mr. SLATER. That is correct.

Mr. O'LEARY. So your product varies along with the degree of regulation?

Mr. SLATER. There is not that much change. We do have little variations in some other States and so on, and so forth. But in this particular one, we have adapted to New York which is as tight as any of them.

Mr. O'LEARY. I noted also that the standard policy that is marketed in Missouri that I first read, is entitled "Extra Cash Hospitalization Indemnity Plan."

As I understand it that seems to be the standard policy which is marketed in most States. It bears that title, "Extra Cash Hospitalization"?

Mr. SLATER. I think so, yes.

Mr. O'LEARY. I note also that the Michigan plan is entitled, "Hospitalization Indemnity Plan", and there is no reference to cash or extra cash that I can see.

Can you tell me why that difference exists?

Mr. SLATER. Well, Mr. O'Leary, there are a lot of differences in the States in what you can say and what you cannot say.

For example, New York says that you cannot say, "tax-free cash" unless you put in a qualifying statement by legal counsel that in fact it is tax free cash.

Now, they say that you can say, "extra cash."

Now, Pennsylvania says that you can't say, "extra cash", but you can say, "tax free cash." Michigan says that you can't say either of those two things. You have got to say, "benefits."

Now we adjust our particular advertising to the wording that the particular States require, but it makes no difference in the benefits, or anything else.

Mr. O'LEARY. Is it the Michigan Insurance Commissioner's rationale that this may be misleading to say "extra cash"?

Mr. SLATER. On "tax-free cash," that's correct.

Mr. CHUMBRIS. Have there been rules by either the State income tax division or the Federal tax rules that this is tax free or nontax free?

Mr. SLATER. Yes, there have been. New York just says that you have to put the lawyers' opinion in there that it is tax-free cash.

Mr. CHUMBRIS. What has been the ruling in New York? Is it tax-free or is it not tax free?

Mr. SLATER. It is tax free; nationwide.

Mr. CHUMBRIS. What is the rationale of the State of New York and the State of Michigan for their interpretation. Certainly they must have given you some reason.

Maybe you ought to put it in the record.

Mr. SLATER. Well, New York says you can put in "tax-free cash" provided you put this lawyers' dissertation. We don't care to put in the lawyers' dissertation, so they say you can put in, "extra cash."

Now Pennsylvania says when you say "extra cash," it means that you are making money. So therefore, you can't say "extra cash," but you can say, "tax-free cash" because **it is meant to be tax-free cash.**

Michigan, on the other hand, says that you can't say "tax free" for the same reason that New York says it. You can't say "extra cash" for the reason that Pennsylvania says it.

They don't think we should be able to say either. Now we have this problem in 50 jurisdictions; that every State wants their own little peculiarities about wording or something else that they think is misleading. We just have to make these changes.

Mr. O'LEARY. Mr. Slater, you know that the staff has gone through a number of the claim files.

Mr. SLATER. I know that, sir.

Mr. O'LEARY. I have one in front of me, No. 5595729. The subject is a 72-year-old male—

Mr. SLATER. Can you repeat the number, please?

Mr. O'LEARY. 5595729; the subject is a 72-year-old male who was confined in the hospital from January 4 to January 16, 1972.

He had hospital insurance in effect with the company since October of 1970.

He was confined in the hospital for extraction of cataracts of both eyes which were removed by one physician, and for treatment of cardiovascular disease by a second physician.

The first physician indicated that the symptoms of cataracts were first noticed in December of 1971. The second physician indicated that he had done an electrocardiogram on this patient in December of 1971.

The physicians' statement seem to indicate that there was no pre-existing condition. However, as I understand it, the company then contacted the hospital requesting information, after having received the physicians' reports, and the hospital advised the company that there had been gradual loss of vision for the past 2 years.

The company then rejected this claim on the basis of preexisting condition.

Doesn't it get pretty difficult to decide whether it is or is not a pre-existing condition? Isn't there a lot of leeway there?

Mr. SLATER. There are some cases that are questionable and we try to settle the matter in favor of the patient where we can.

There are many instances where a patient takes out a policy and goes to the hospital 2 or 3 days later for a condition that has been existing for 6 months. Obviously there is no question about that particular case.

There are others where there are some questions, and on occasion we make a mistake. Now I haven't been able to look at this particular file well enough to explain it to you, but I do not think that there was any error on our part on this particular case.

Mr. O'LEARY. The physicians' statement is only one factor which is taken into consideration?

Mr. SLATER. Or the hospital; the hospital and the physician are the only two things we look at. The statement of the hospital or the physician. We do not make any other checks on the matter.

Mr. O'LEARY. And the company, it is fair to say, makes the decision, and if the policyholder does not agree with that decision, I take it he then has to retain a lawyer and sue on the basis of the facts?

Mr. SLATER. It very seldom goes to that. They generally write the insurance department, and as a matter of fact, we have just gone through an examination—what they call a triennial examination of all the insurance commissioners.

If I remember correctly, they found one claim that they thought we were wrong on.

We get letters from the departments, which, in turn, they are getting from policyholders. Those letters are investigated thoroughly.

Very seldom do we ever find that the company has been wrong in the final settlement. After all, insurance is basically to pay claims. That's the reason for insurance. That is our business, and we want to pay as many as we can that are legitimate.

Mr. O'LEARY. As I understand it, if a policyholder does not agree with you, his only recourse is either to bear the burden and expense of either getting counsel or complaining to the insurance commissioner.

Mr. SLATER. What they do, Mr. O'Leary, is if the policyholder does not agree with what they get from the claims department, they write to the president or the chairman of the board. Then we in turn look back into this thing or have it relooked at.

Then the next recourse is generally to the insurance department.

Mr. SHARP. Thank you; now Mr. Slater, National Liberty Corp. provided the subcommittee with claims data on your most popularly sold policy, that is the supplemental hospital indemnity policy. The so-called NH-10 policy.

For the block of policies sold through the mail in 1970, the claims data on this same block for 1970-71, and the first 2 months of 1972, shows the following:

The company received 78,577 claims, of which 30,291, or nearly 40 percent, were rejected and nothing was paid.

Of the 30,000, 12,000 were rejected because of pre-existing health conditions.

Mr. Slater, what kind of insurance protection is this? What kind of protection is a person getting here?

*NH-10 Claims Data for 1970-1971 and January and February 1972 on All
NH-10 Policies Sold by National Liberty in 1970*

Number of claims received-----	78,577
Number of claims rejected with nothing paid-----	¹ 30,291
Number of claims paid:	
\$1-\$99 -----	27,119
\$100-\$499 -----	20,718
\$500-\$999 -----	326
\$1,000-\$1,999 -----	111
\$2,000-\$4,999 -----	10
\$5,000-\$9,999 -----	1
\$10,000 and over-----	1
Total number of claims paid-----	48,286

¹ 12,213 claims were rejected because of "pre-existing" health condition, 5,660 were rejected because there was no hospital confinement nor surgery within the terms of the policy.

Source: Senate Antitrust and Monopoly Subcommittee.

Derived from: Computer Print-Out of Claims Paid and Rejected submitted by National Liberty Corp. to the Subcommittee. Copy of Print-Out is contained in the Subcommittee files.

NATIONAL LIBERTY SUMMARY OF COMPUTER PRINTOUT OF CLAIMS PAID AND REJECTED ON NH-10 POLICIES

1970:		
Number of paid.....		14,963
Amount paid.....	\$1,824,010.49	
Number rejected.....		12,658
Rejected reason 20 (not insured).....		1
Rejected reason 21 (no confinement or no surgery).....		2,050
Rejected reason 22 (lapse).....		532
Rejected reason 23 (not covered).....		1,711
Rejected reason 24 ("preexisting" health condition).....		6,821
Rejected reason 25 (waiver).....		16
Rejected reason 30 (rescind).....		5
Rejected reason 40 (abandon).....		407
Rejected reason 50 (duplicate claims).....		841
Rejected reason 60 }.....		113
Rejected reason OT } (other).....		161
1971:		
Number of paid.....		28,939
Amount paid.....	\$3,658,037.46	
Number rejected.....		15,980
Rejected reason 20 (not insured).....		9
Rejected reason 21 (no confinement or no surgery).....		3,179
Rejected reason 22 (lapse).....		1,080
Rejected reason 23 (not covered).....		3,051
Rejected reason 24 ("preexisting" health condition).....		5,037
Rejected reason 25 (waiver).....		8
Rejected reason 30 (rescind).....		7
Rejected reason 40 (abandon).....		470
Rejected reason 50 (duplicate claims).....		2,798
Rejected reason 60 }.....		245
Rejected reason OT } (other).....		96
1972:		
Number of paid.....		4,393
Amount paid.....	\$471,482.95	
Number rejected.....		1,571
Rejected reason 20 (not insured).....		35
Rejected reason 21 (no confinement or no surgery).....		431
Rejected reason 22 (lapse).....		117
Rejected reason 23 (not covered).....		358
Rejected reason 24 ("preexisting" health condition).....		351
Rejected reason 25 (waiver).....		1
Rejected reason 30 (rescind).....		1
Rejected reason 40 (abandon).....		20
Rejected reason 50 (duplicate claims).....		197
Rejected reason 60 }.....		59
Rejected reason OT } (other).....		1
Other:		
Number of paid.....		21
Amount paid.....	\$3,491.59	
Number rejected.....		82
Rejected reason 20 (not insured).....		0
Rejected reason 21 (no confinement or no surgery).....		0
Rejected reason 22 (lapse).....		0
Rejected reason 23 (not covered).....		0
Rejected reason 24 ("preexisting" health condition).....		4
Rejected reason 25 (waiver).....		0
Rejected reason 30 (rescind).....		1
Rejected reason 40 (abandon).....		1
Rejected reason 50 (duplicate claims).....		1
Rejected reason 60 }.....		1
Rejected reason OT } (other).....		75

Note: According to National Liberty Corp.: "The number of claims shown on the computer listing of claims paid and rejected varies slightly from the summarization of the earned premium, claims incurred loss ratio figures; however, it is estimated that in excess of 90 percent of the claims paid and rejected on all NH-10 policies issued in 1970 are listed."

(Submitted to the Subcommittee by National Liberty Corporation)

SUMMARIZATION OF EARNED PREMIUMS, CLAIMS INCURRED AND LOSS RATIOS ON
NATIONAL HOME—NH10 BROADMARKET AND GOLD STAR AND MARKET TESTS—
1970 ISSUES

Total number policies issued (renewed)-----	270, 237
Number policies in force, December 31, 1970-----	215, 604
Number policies in force, December 31, 1971-----	150, 326
Number policies in force, February 28, 1972-----	142, 661
Earned premium 1970-----	6, 334, 900
Number claims incurred (and paid) 1970-----	16, 228
Amount claims incurred (and paid) 1970-----	1, 946, 900
Loss ratio 1970-----	30. 7
Earned premium 1971-----	13, 923, 100
Number claims incurred (and paid) 1971-----	32, 838
Amount claims incurred (and paid) 1971-----	4, 161, 800
Loss ratio 1971-----	¹ 29. 9
Earned premium January 1-February 28, 1972-----	1, 638, 300
Number claims incurred (and paid) 1972-----	2, 518
Amount claims incurred (and paid) 1972-----	377, 800
Loss ratio January 1-February 28, 1972-----	² 23. 1

¹ Due to the lag in filing claims, it is estimated that as of April 1972 approximately 90 percent of the payable claims incurred in 1971 have been paid.

² Due to the lag in filing claims, it is estimated that as of April 1972 approximately 60 percent of the payable claims incurred in 1972 have been paid.

Guaranteed renewable reserves are not included.

Note: Claims are those received, processed, and closed through April 25, 1972.

Source: National Liberty Corporation.

Mr. SLATER. Well, insurance is based on broad averages, and I assume that you can take any block of business and prove about anything that you want with it.

But if you look at our claims in the aggregate, 10 percent of them are rejected because of preexisting conditions, and that we do pay out—and we paid out, I think, over 119 claims last year, and over \$30 million.

Mr. SHARP. Excuse me, Mr. Slater. We are talking about the supplemental hospital indemnity policy. From this information which you supplied to the subcommittee, and from our conversations with your people, you have told us that this is your most popular policy sold. This is the policy you advertise through these fliers and fillers in the newspapers. This is the policy we are discussing.

Your same data shows that for this same period of time, that you paid out a little over \$6 million on these policies over these two years period.

Mr. SLATER. I think that if you go back to this particular first chart that we showed you, we do not anticipate that we will pay out any more than 35 percent in the first 2 years, and then it starts rising.

If I remember your figures correctly, you were talking about what was done in the first 2 years. We do not anticipate paying out very high claims.

Mr. SHARP. Well, doesn't the fact that 40 percent of the claims are rejected in the first 2 years, doesn't that really show that the people do not understand this preexisting health condition clause?

Mr. SLATER. Well, this may be one explanation. But there may be another explanation, and I think it is a very valid one; that people sort of try and see whether or not they can get it through.

They may very well know that it exists, but they still send it in saying, "Well, let's see whether or not it will work."

Mr. SHARP. Are you suggesting that people are trying to cheat you?

Mr. SLATER. I think you have this not only in our kind of insurance. You have—the other individual insurance policies have a contestable period for 2 years where they get into post claim underwriting.

Mr. SHARP. Well, here is an interesting letter from your files on this point—file No. 5608254.

We had a witness who testified, I think it was May 10, and he said that people chopped their fingers off sometimes. They had a case where they chopped their fingers off and would collect on their insurance.

Now in this instance here, in this case, it doesn't involve that. Two policyholders with the same name were confused. A Detroit, Mich., policyholder received a card from your company saying that they were processing his claim, when it was actually a St. Louis policyholder with the same name that was making a claim.

The Detroit policyholder writes as follows:

I just received this card in the mail that you are processing a claim from me immediately. But I must say somewhere or somehow you have gotten your records or your files mixed up, as I am not sick and pray to Jehovah I will not get sick.

I have not filled out a form for a sick claim. Last week I did send a check for \$23.79. I think it was, but it was my payment on my insurance.

Please don't make me a claim because I am not entitled to anything as I am perfectly well. Please check the mistake. Maybe it was someone else. I appreciate your doing your duty and your job, but please check your files again. Please don't send me any money or checks.

Thank you very much.

Doesn't that show that most people are really honest?

Mr. SLATER. Mr. Sharp, we don't make any claim that we are perfect. We get 45,000 pieces of mail a day. We send out 65,000 pieces of mail a day.

I think that with this being the case, we can make a relatively few errors. Now we did last year issue a million policies. This year we expect to issue considerably more than that.

Certainly we are going to make errors on some. We try to have proper controls to keep these errors and things down to a minimum, and by the complaints we are getting from the insurance department, they are very small.

Mr. SHARP. You say the complaints you are getting from insurance departments are small, sir?

Mr. SLATER. Yes. The complaints that we got from the insurance department in Pennsylvania. I think, were 277, of which there were 33 out of that group that could be in any way criticism of our company's handling of the particular matters involved.

Mr. SHARP. Well, getting back to these facts and figures that you supplied to the subcommittee. Of the 30,000 claims that were rejected in the first 2 years on these 1970 supplemental hospital indemnity policies sold, 5,660 were rejected because there was no hospital confinement, nor surgery, within the terms of the policy.

Now this is almost 20 percent of the people rejected. Don't you feel here again that the people did not understand the terms of your policy?

Mr. SLATER. I could assume that that is correct. But because you

happen to find a relatively few who send us in claims who have never been in the hospital at all, I don't assume—I don't think you should assume that because relatively few do that, that the vast majority do not understand.

Mr. SHARP. Mr. Slater, don't a number of your supplemental hospital policies, contain what is called an elimination period. You can't collect for maybe the first 3, 4, 5, 6 or 7 days, while you are in the hospital depending on the policy?

Is that true?

Mr. SLATER. We do have policies that have the elimination periods, but they also have the option to buy first-day coverage if they so desire.

Mr. SHARP. Do you think they understand that when you have 5,600 of these claims out of 30,000 being rejected because of the fact that there was no hospital confinement nor surgery within the terms of the policy?

Mr. SLATER. Well, remember that we had 200,000 claims. We had 200,000 claims altogether.

Mr. SHARP. No. You had 78,000 claims received, according to the information supplied on a computer printout. May I refer you to a computer printout supplied by your company on this block of NH-10 policies sold in 1970. Do you have a copy?

Mr. SLATER. Well, the figures I am quoting are for all the claims. We had 225,000 claims.

Mr. SHARP. Well, can I direct your attention to the NH-10 policy?

Mr. SLATER. I think this is true of any insurance, Mr. Sharp. It is not peculiar to ours.

Mr. SHARP. Why is that, sir? Why isn't it peculiar to yours? We are dealing specifically—

Mr. SLATER. Well, let me ask you, Mr. Sharp, if I may—do you understand your group insurance policy?

Mr. SHARP. I beg your pardon?

Mr. SLATER. Do you understand your group insurance policy?

Mr. SHARP. Yes. I understand that I get 95 cents back on the dollar, and I look at your policy here—

Mr. SLATER. I don't think that is the understanding of your policy. That is looking at some figures.

Do you understand your automobile insurance policy?

Mr. SHARP. I think I do, sir.

Mr. SLATER. Well, I am going to admit that I don't.

Mr. SHARP. Pardon me?

Mr. SLATER. I am willing to admit that I don't.

Mr. SHARP. There are a lot of things that I don't understand.

One thing I don't understand is the fact that you have received 78,000 claims, and you have paid out 48,000 of them. Of the 48,000 claims, according to your own company figures, the average paid claim is \$125, despite your advertisement of \$600 tax-free cash, or extra cash.

Now, I don't personally understand this. Maybe you can clarify this for me.

Mr. SLATER. Well, it depends on—the ad stated \$600 per month, or \$20 a day. Now, if the person has a 5-day waiting period, and I think the average claim is \$160 in our company, so that means that the stay in the hospital—11½ days is the average stay in the hospital.

The average stay is 11.5 days, but one out of 16 is over 30 days.

Mr. SHARP. What is the average hospital care cost in this country? Do you have any idea?

Mr. SLATER. The average claim payment in 1971 was \$160.

Mr. SHARP. No, no. What I am asking you is—I'm sorry. Do you have any idea, do you think the consumers of this country have any idea, as to how much in 1971 hospital in-patient care for one person for 1 day costs?

Mr. SLATER. I think Mr. Sharp we are talking here about supplemental coverage, not the basic coverage. This coverage is not intended to pay the entire hospital bill.

Mr. SHARP. Could you answer my question, sir? Do you have any idea whether or not the consumers of this country know—do you know how much hospital in-patient care for one person for 1 day costs in 1971? Do you have any idea?

Mr. SLATER. Well, I know in the Philadelphia hospitals, it is \$192 a day.

Mr. SHARP. And your policy is paying \$20 a day?

Mr. SLATER. But we are only providing the supplemental care—costs incidental to hospital confinement, not the hospital confinement, per se.

Mr. SHARP. Well, sir, according to your survey, the material filed with the Security and Exchange Commission, the average age of your policyholder is 57 years. That is the age which you used to amortize your cost to the SEC.

Now 57 years is the average age, and most of the cases that we went through involved mostly people about 65. Most people are not working after 65, so therefore, if they are not employed, they do not have group insurance.

Mr. SLATER. They have medicare.

Mr. SHARP. Are you saying that your policies are a supplement to medicare?

Mr. SLATER. We are supplemental to hospital benefits coverage whatever it may be, including medicare.

Mr. SHARP. In 1971 hospital in-patient care for one person for 1 day you say in Philadelphia costs \$192, do you put that in your advertising?

Is it displayed properly in your advertising that hospital care costs a hundred and some dollars a day in the Philadelphia area, and you advertise in the Philadelphia papers?

Mr. SLATER. I don't think we put that particular fact in, but we do put in the fact that hospital costs are rising; that the basic coverages are not providing for other needs, and that these coverages are helping to make up the difference.

I think one of the headlines of our ads says that when you got your bill, it was enough to put you back in the hospital again.

Mr. SHARP. The average premium for your policyholders you say was \$70?

Mr. SLATER. On that order—\$70.

Mr. SHARP. Now with respect to this same block of policies sold in 1970—NH-10, supplemental hospital policies—you sold a total of 270,237. And as of 2 years and 2 months later, you only have, according to your figures, 142,661 policies in force. That is almost a little more than half.

Is this because of the preexisting condition clause?

Mr. SLATER. I think what you have here is a situation where policies are renewed, you have a substantial lapse in the first 2 years, and you have a substantial loss in life insurance policies in the first 2 years, as well.

Mr. SHARP. Well, I am talking, sir, about NH-10, the supplemental hospital benefit policy.

You presented a chart, chart 4 here. Now in this chart 4, the simple average of the black dots is 62 percent, is it not?

Is that how you get the 60 to 65 percent? Is that a simple average?

Mr. SLATER. No. It takes into consideration not only the rates, but it takes into consideration the premiums.

Mr. SHARP. Earlier, you made the statement in your testimony that as the business matures, I take it as the 270,000 mature, we know that in the first 2 years 47 percent have terminated for one reason or another.

According to your actual data, based on the total termination rates supplied to the State insurance department and to the subcommittee, you would have only 13 percent of the business sold in force after 14 years on that chart.

Isn't that correct?

Mr. SLATER. I think, Mr. Sharp, if you look at the precise experience in the long report on page—, following page 14—you see there the business that you have \$343,000 still in force out of 859 of original premiums.

Following page 14 of the long report—

Mr. SHARP. Oh, I see.

Mr. SLATER. If you look there at the 1960 business, and take 1961 as the year, you have 859, and you still have \$343,000 of that still in force at the end of 10 years.

Mr. SHARP. Well, let's look at this 1970 business, sir. As to the 1970 business, you have left 30 percent of that business at the end of the 14 years. Isn't that correct?

Mr. SLATER. No, sir. I don't think those are our figures at all. We have considerably more than that. You can take an extrapolation, Mr. Sharp, if you wish, but that does not necessarily mean that is the fact.

Mr. SHARP. The black line that you presented the subcommittee, is that weighted at all? Is that average weighted for the termination of policies—terminations on 1970 business 14 years later in 1984?

Mr. SLATER. We will have a 95-percent loss ratio on the business that is then in force.

Mr. SHARP. But that is not a weighted loss ratio.

Mr. SLATER. 60 to 65 is weighted. That 95 that I just referred to is not.

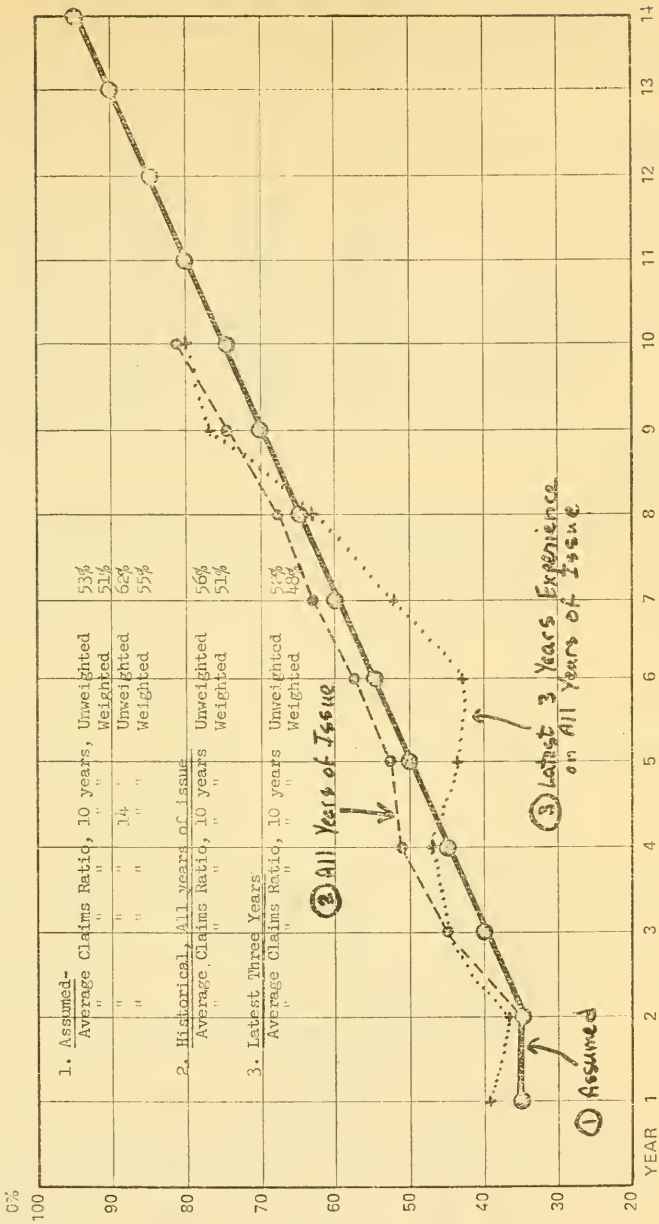
Mr. SHARP. Well, you stated before that it is a simple average, sir.

Mr. PATTY. No. I said it was not a simple average.

Mr. SLATER. I said it was not a simple average.

Mr. SHARP. Mr. Chairman, I would like to introduce into the record at this point all the actuarial tables, studies, projections, including those furnished by this company to both the SEC and the State insurance departments, as well as this subcommittee.

NATIONAL LIBERTY GROUP ANTICIPATED CLAIMS RATIO
(SUPPLEMENTAL HOSPITAL INDEMNITY)



ACCUMULATED RESULT OF 60-65% OF PREMIUMS PAID OUT IN
CLAIMS QUALIFIES AS AN A+ RATING IN NEW YORK STATE
Red Dotted Line Indicates Actual Experience — All Years of Issue

NATIONAL LIBERTY GROUP
CALCULATION OF WEIGHTED LOSS RATIOS ON MASS MERCHANDISED BUSINESS
[In percent]

Policy year	Lapse rate (1)	In-force at beginning of year ¹ (2)	Assumed loss ratio (3)	Average historical loss ratio (4)	Average loss ratio last 3 years (5)
1	30.0	100.0	35	35	39
2	20.0	70.0	35	35	36
3	15.0	56.0	40	44	44
4	11.0	47.6	45	51	46
5	8.0	42.4	50	53	43
6	7.2	39.0	55	56	42
7	6.4	36.2	60	63	52
8	5.8	33.9	65	67	64
9	5.4	31.9	70	74	77
10	5.0	30.2	75	81	² 80
11	4.8	28.8	80	82	² 80
12	4.6	27.5	85		
13	4.4	26.3	90		
14	4.2	25.1	95		

¹ Weighting factor.² Last 2 and 1 years.

Aggregate loss ratios	Unweighted (percent)	Weighted (percent)
1. Assumed, 10 yrs.-----	$\sum_{t=1}^{10} \frac{\text{Col. (3)}}{10} = 53$	$\frac{\sum_{t=1}^{10} \text{Col. (2)} \times \text{col. (3)}}{\sum_{t=1}^{10} \text{Col. (2)}} = 48$
2. Assumed, 14 yrs.-----	Similarly for 14 = 62	Similarly for 14 yrs. = 55
3. Historical, 10 yrs.-----	$\sum_{t=1}^{10} \frac{\text{Col. (4)}}{10} = 56$	$\frac{\sum_{t=1}^{10} \text{Col. (2)} \times \text{col. (4)}}{\sum_{t=1}^{10} \text{Col. (2)}} = 51$
4. Last 3 yrs, 10 yrs.-----	Similar col. (5) = 52	Similar col. (5) = 48

NOTES

Col. (1)—Lapse rates from National Liberty Corp. Prospectus dated Aug. 26, 1971.

Col. (3), (4), (5)—Furnished by company.

NATIONAL LIBERTY CORP.
LOSS RATIOS ON ALL MASS MERCHANDISED A & H BUSINESS
[In percent]

Policy year	Year sold											Average last 3 years
	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	
1	43	44	47	40	35	30	43	45	42	36	40	39
2	40	41	40	33	30	31	38	39	35	35		36
3	50	53	46	39	33	37	43	44	45			44
4	62	61	56	43	36	39	48	52				46
5	64	63	59	47	37	42	50					43
6	72	70	63	47	39	41						42
7	82	75	64	48	43							52
8	83	76	65	50								64
9	89	77	65									77
10	83	77										1 80
11	80											1 80

¹ Last 2 and 1 years.

Note: Loss ratios increased by 3 percent over those supplied by company as estimate of understatement occasioned by omission of increase in guaranteed renewable reserves.

NATIONAL HOME ASSURANCE COMPANY OF NEW YORK

ACTUARIAL MEMORANDUM DESCRIBING BASIS OF PREMIUM RATES FOR POLICY FORM
NO. NHNY-10-669*Morbidity for hospital benefit*

The source for the expected morbidity assumptions is the 1967 Reports of the Society of Actuaries, Experience under Individual Medical Expense policies, 1964-65. (Pages 76-113)

For the hospital benefit the graduated claim frequency and claim costs were used and were adjusted as follows:

1. Individual claim costs were made equal to the sums of 50% of the Female and 50% of the Male experience.

2. Claim costs were increased 10% to adjust for Lifetime Hospital Benefit.

3. Claim costs were increased 25% to allow for non-underwritten business and the revision requested in the "Pre Existing Conditions" clause.

4. For each age group, over age group 75-79, the claim costs were estimated to be equal to 118% of the next preceding age group.

5. Claim costs were adjusted as follows for ages 65 and over: (Hospital benefit for first 90 days is 70% of basic benefit and 100% for the 91st day and following.)

Age:	Claim costs as percent of full benefit claim costs	
65-69	-----	72.4
70-74	-----	73.0
75-79	-----	73.6
80-84	-----	74.2
85-89	-----	74.8
90 and over	-----	76.0

TOTAL TERMINATION RATES

[In percent]

Ages	Years							
	1	2	3	4	5	6-10	11 to 15	16 to 20
16 to 44	42	25	19	17	15	13	12	11
45 to 49	38	24	17	15	13	12	10	10
50 to 54	35	22	16	14	13	11	12	13
55 to 59	28	18	15	12	11	12	13	14
60 to 64	22	16	13	12	12	13	14	20
65 to 69	24	18	15	13	12	14	20	25
70 to 74	26	20	18	16	17	20	25	33
75 to 79	29	23	21	20	18	25	28	37
80 to 84	32	25	23	25	26	28	37	50
85 to 89	38	32	30	30	30	37	50	50
90 and over	42	40	40	40	40	50	50	50
Composite children, 0 to 18	42	25	19	17	15	50	80	100

SELECTION FACTORS BY DURATION

[In percent]

	1st year	2d year	3d year	4th year	5th year	6th year	7th year and on
To age 44	75	85	100	105	110	115	(1)
45 to 59	70	80	100	105	110	115	(1)
60 to 64	65	75	100	105	110	115	(1)
65 and over	60	70	100	105	110	115	(1)

† Each succeeding year will increase 3 percent.

Guaranteed renewable reserves:

Reserves are valued on a 2-year preliminary term basis using the 1956 Inter-Company Hospital and Surgical Tables and the 1958 CSO with 3% interest.

Net premium formula for hospital benefit:

Present value of premiums during 1st 20 years

Minus present value of claim costs in 1st 20 years

Plus present value of terminal reserve for each policy surviving 20 years.

All amounts discounted at $4\frac{1}{2}\%$.ADDITIONAL ADJUSTMENT FOR SPECIAL BENEFITS (AS A PERCENT OF THE HOSPITAL BENEFIT NET PREMIUM¹)

Age	Waiver of premium (percent)	Dismember- ment (percent)
0 to 18 (composite children).....		1.0
16 to 49.....	1.00	1.0
50 to 54.....	1.00	1.0
55 to 59.....	1.00	1.0
60 to 64.....	1.25	1.0
65 to 69.....	1.25	1.0
70 to 74.....	1.50	1.0
75 to 79.....	1.50	1.0
80 to 84.....	1.50	1.0
85 and over.....	1.50	1.0

¹ Hospital benefit standardized at \$400 per month.*Gross premium formula*

G.P.=N.P.*.50 with grading, banding and rounding.

This provides for general overhead expenses, claim adjustment expenses, premium taxes, acquisition expense and contingencies. This results in approximately a 60% (under age 60) and 60+ % (for all ages over 60) ultimate cumulative loss ratio.

The relationship of modes are as follows:

Monthly=10% of annual

Quarterly=28.5% of annual

Semi-Annual=54% of annual

NATIONAL HOME LIFE ASSURANCE COMPANY, ST. LOUIS, MISSOURI

ACTUARIAL MEMORANDUM DESCRIBING BASIS OF PREMIUM RATES FOR POLICY
FORM—NH 10-669*Morbidity for hospital benefit*

The source for the expected morbidity assumptions is the 1967 Reports of the Society of Actuaries, Experience under Individual Medical Expense policies, 1964-64. (Pages 76-113)

For the hospital benefit the graduated claim frequency and claim costs were used and were adjusted as follows:

1. Individual claim costs were made equal to the sum of 50% of the Female and 50% of the Male experience.

2. Claim costs were increased 10% to adjust for Lifetime Hospital Benefit.

3. Claim costs were increased 20% to allow for non-underwritten business.

4. For each age group, over age group 75-79, the claim costs were estimated to be equal to 118% of the next preceding age group.

5. Claim costs were adjusted as follows for ages 65 and over: (Hospital benefit for first 90 days is 50% of basic benefit and 100% for the 91st day and following.)

Age:	Claim costs as percent of full benefit claim costs
65-69	54
70-74	55
75-79	56
80-84	57
85-89	58
90 and over.....	60

*Sum of N.P. for hospital benefits and adjustments for special benefits.

6. Claim costs for hospital benefit where elimination period for sickness varies, were derived from continuation studies of similar policies sold by mail and underwritten by related company.

[In percent]

Elimination period for sickness ¹	Ages	
	0 to 49	50 and over
0.....	100	100
3.....	75	80
4.....	70	75
5.....	65	71
6.....	61	67
7.....	57	63

¹1st day coverage for accident in all cases.

TOTAL TERMINATION RATES

[In percent]

Ages	Years							
	1	2	3	4	5	6 to 10	11 to 15	16 to 20
16 to 44.....	42	25	19	17	15	13	12	11
45 to 49.....	38	24	17	15	13	12	10	10
50 to 54.....	35	22	16	14	13	11	12	13
55 to 59.....	28	18	15	12	11	12	13	14
60 to 64.....	22	16	13	12	12	13	14	20
65 to 69.....	24	18	15	13	12	14	20	25
70 to 74.....	26	20	18	16	17	20	25	33
75 to 79.....	29	23	21	20	18	25	28	37
80 to 84.....	32	25	23	25	26	28	37	50
85 to 89.....	38	32	30	30	30	37	50	50
90 and over.....	42	40	40	40	40	50	50	50
Composite, children 0 to 18..	42	25	19	17	15	50	80	100

Note: Includes voluntary and termination by death.

SELECTION FACTORS BY DURATION

[In percent]

	1st year	2d year	3d year	4th year	5th year	6th year and on
To age 44.....	65	80	100	105	110	115
45 to 59.....	60	75	100	105	110	115
60 to 64.....	55	70	100	105	110	115
65 and over.....	50	65	100	105	110	115
Maternity.....	50	133	100	100	100	100

Guaranteed renewable reserves

Reserves are valued on a 2-year preliminary term basis using the 1956 Inter-Company Hospital and Surgical Tables and the 1958 CSO with 3% Interest.

Net premium formula for hospital benefit

Present value of premiums during 1st 20 years.

Minus present value of claim costs in 1st 20 years.

Plus present value of terminal reserve for each policy surviving 20 years.

All amounts discounted at 4½%.

ADDITIONAL ADJUSTMENT FOR SPECIAL BENEFITS (AS A PERCENT OF THE HOSPITAL BENEFIT NET PREMIUM ¹)

Age	Nurse at home	Waiver of premium	Dismemberment	Simultaneous confinement
0 to 18 (composite).....	1.0	-----	1.0	-----
16 to 49.....	2.0	1.00	1.0	.5
50 to 54.....	3.0	1.00	1.0	.5
55 to 59.....	3.0	1.00	1.0	.5
60 to 64.....	3.0	1.25	1.0	.5
65 to 69.....	4.0	1.25	1.0	.5
70 to 74.....	5.0	1.50	1.0	.5
75 to 79.....	5.0	1.50	1.0	.5
80 to 84.....	5.0	1.50	1.0	.5
85 and over.....	6.0	1.50	1.0	.5

¹ Hospital benefit standardized at \$400 per month. No elimination period for accident or sickness.

Gross premium formula

G.P. = N.P.*/.50 with grading, banding and rounding.

This provides for general overhead expenses, claim adjustment expenses, premium taxes, acquisition expense and contingencies. This results in approximately a 53-58% ultimate cumulative loss ratio, depending on age.

The relationships of modes are as follows:

Monthly—10% of Annual

Quarterly—28.5% of Annual

Semi-Annually—54% of Annual

LYBRAND, ROSS BROS. & MONTGOMERY,
Philadelphia, June 4, 1971.

Mr. JACK RADOV,
Staff Accountant, Room 665, Securities and Exchange Commission,
Washington, D.C.

DEAR MR. RADOV:

National Liberty Corporation
File Number 2-33973

At the request of our client National Liberty Corporation, we enclose the following:

1. A schedule prepared by the company showing direct response marketing expenditures and total annualized renewal premium obtained as a result of such expenditures.

2. Financial statements of the company's subsidiary, National Home Life Assurance Company, and the report of Peat, Marwick, Mitchell & Co. thereon.

3. A copy of the letter to our firm from Peat, Marwick, Mitchell & Co. concurring with our letter to you dated June 1, 1971.

4. In accordance with your suggestion, a draft of the proposed revisions to the format of the Consolidated Statement of Income appearing on page 6 of the company's registration statement. The principal portion of the DeMoss agency activities would be included in insurance operations because it is an integral part of such operations. It should be noted that the non-insurance activities will consist principally of data processing company which will show 1970 revenues of approximately \$1,000,000 and related expenses of approximately \$3,500,000. Although this presentation results in a loss, the company actually shows a profit on an individual company basis. The reason for the difference is the elimination of intercompany revenues of approximately \$3,000,000. Consequently, to try to isolate the activities of such a company when its principal source of revenue comes from the consolidated group would

*Sum of N.P. for hospital benefits and adjustments for special benefits.

appear to be misleading and accordingly the financial statements included in the registration statement on page 6 did not separate such operations.

5. An explanation of the Linton B Table used in setting the company's premium rates and determining persistency (see our letter of June 1, 1971) is as follows:

a. *The Linton B Table*

The Linton tables of termination rates are the best known, most accepted and most often used for employing the termination of policies in actuarial calculations. Mr. M. Albert Linton, Actuary and later President of Provident Mutual Life Insurance Company, published these tables in Volume No. XIII of the Record of the American Institute of Actuaries. The termination of policies for reasons other than death was at that time combined with the American Men Mortality Select Table rates at age 35. For the purposes of premium and agency compensation calculations these termination or lapse rates were translated to persistency rates. The persistency rates show the proportions of original business remaining in force.

Since their publication, it was found that modifying one of the Linton patterns and combining it with an up-to-date or otherwise appropriate mortality table permitted continued use of some form of Linton table. Therefore, one encounters varying percentages of Linton A, B or C tables or tables based on different lapse rates in early policy years merged into a Linton table for later years.

The Linton B lapse rate (terminations for reasons other than death) for the first 10 policy years are shown below. They show the percentages of business lapsing in each policy year out of the business entering such policy year.

<i>Policy year:</i>	<i>Lapse rate</i>
1	20.0
2	12.0
3	10.0
4	8.8
5	8.0
6	7.2
7	6.4
8	5.8
9	5.4
10	5.0

b. *How Linton B Table was used at National Liberty Corporation*

The exposure draft of the *Audits of Life Insurance Company's* uses the word "withdrawals" for "lapses" above. It states that withdrawal rates should be representative of the company's experience. In keeping with this, the lapse rates used in calculating the natural reserves for National Liberty were obtained after a study of the Companies' experience.

The grading of the following lapse rates comes from such a study:

<i>Policy year:</i>	<i>Annual lapse rate</i>
1	30%
2	20%
3	15%
4	11%
5 and later	Linton B

The blending into Linton B is felt to contain an element of conservatism. It is quite common for lapsation patterns to differ from one

of the Linton tables by having a much higher percentage in the early policy years and then a much lower percentage of that table after the third or fourth policy year. In effect, this states that those policyholders who persist for a given experience of lapsation of a body of policyholders do so at a much better rate than indicated by the higher early lapsation. In the case of National Liberty, since an age 57 was assumed as the average age of issue, the period of amortization was 43 years. The thinking applies equally well to guaranteed renewable as for noncancellable and life insurance business.

A letter to you from the firm of Peat, Marwick, Mitchell & Co. explaining the basis for their concurrence with our letter of June 1, 1971 is being delivered to you under separate cover.

We trust the above information is sufficient for your needs and should you need further explanation, we shall be pleased to meet with you to discuss this matter.

Very truly yours,

F. LOMBARDI.

Enclosures.

Hand Delivered.

NATIONAL LIBERTY CORPORATION

	Direct response marketing expenditures	Total annualized renewal premium
1966.....	\$5, 132, 000	\$10, 044, 000
1967.....	6, 283, 000	10, 293, 000
1968.....	8, 318, 000	12, 572, 000
1969.....	13, 146, 000	18, 722, 000
1970.....	24, 102, 000	32, 536, 000

NATIONAL LIBERTY CORPORATION AND SUBSIDIARY COMPANIES CONSOLIDATED
STATEMENT OF INCOME (A)

The following consolidated statement of income of National Liberty Corporation and Subsidiary Companies has been examined by Lybrand, Ross Bros. & Montgomery, independent certified public accountants, and their opinion with respect thereto (which is based in part on the report of other certified public accountants) appears elsewhere in this Prospectus. This statement should be read in conjunction with the other consolidated financial statements and related notes of National Liberty Corporation and Subsidiary Companies included elsewhere herein.

	Year ended December 31				
	1966	1967	1968	1969	1970
Revenues:					
Insurance Operations:					
Premium income:					
Accident and health					
Life					
Commissions					
Investment income:					
Interest, principally bonds					
Dividend income					
Real estate income					
Other					
Investment expense					
Other:					
Service revenue (principally data processing)					
Investment income					
Costs and expenses:					
Insurance operations:					
Accident and health and other benefits					
Increase in policy reserves					
Commissions					
General insurance expenses					
Taxes, licenses and fees					
Increase in loading and cost of collection on deferred and uncollected premiums					
Increase in deferred policy acquisition cost					
Other:					
Cost of service revenue					
General and administrative expense					
Income before income taxes, etc.	\$5,210,545	\$4,501,696	\$5,995,790	\$10,245,162	\$12,990,002
Provision for income taxes:					
Deferred (c)	1,957,372	1,748,397	2,397,601	3,739,103	3,517,491
State	(6,000)	37,000	5,700	25,285	34,230
	1,951,372	1,785,397	2,403,301	3,764,388	3,551,721
Income before investment gains (losses) and extraordinary gain	3,259,173	2,716,299	3,592,489	6,480,774	9,438,281
Investment gains (losses), net of related deferred income taxes	410	196,839	79,688	(167,047)	(682,948)
Income before extraordinary gain	3,259,583	2,913,138	3,672,177	6,313,727	8,755,333
Extraordinary gain on sale of portfolio of insurance, net of related deferred income taxes of \$1,082,958					3,353,726
Net income	3,259,583	2,913,138	3,672,177	6,313,727	12,109,059
Per share of common stock (c):					
Income before investment gains (losses) and extraordinary gain	.41	.34	.43	.74	1.07
Investment gains (losses)		.02	.01	(.02)	(.08)
Income before extraordinary gain	.41	.36	.44	.72	.99
Extraordinary gain					.38
Net income	.41	.36	.44	.72	1.37

Note: See accompanying notes to consolidated statement of income. Per share amounts have been adjusted to reflect the proposed 4-for-3 stock distribution in April 1971.

LYBRAND, ROSS BROS. & MONTGOMERY,
Philadelphia, June 28, 1971.

Mr. CHARLES A. OGLESBAY, Jr.,
Securities and Exchange Commission, Division of Corporate Finance, Washington, D.C.

DEAR MR. OGLESBAY: At your request, we enclose a schedule, prepared by National Liberty Corporation, of policies in force for the direct response accident and health insurance business written the Company's life insurance subsidiaries. The analyses of deferred policy acquisition costs will be forwarded to you early this week.

If we can be of any further assistance, do not hesitate to contact us.

Very truly yours,

DIRECT RESPONSE—ACCIDENT AND HEALTH INSURANCE COUNT OF POLICES IN FORCE

	1966	1967	1968	1969	1970
In force beginning of year.....	266,300	314,700	356,200	397,600	486,600
Issued during the year.....	134,300	127,300	139,200	183,700	391,000
Terminated (or not renewed during the year).....	85,900	85,800	97,500	94,700	120,400
In force at end of year.....	314,700	356,200	397,600	486,600	757,200
Termination ratio ¹ (percent).....	21.4	19.4	19.7	16.3	13.7

¹ Number of policies terminated divided by the sum of the policies in force at the beginning of year and the number of policies issued during the year.

Note: Policy count includes only policies in force paying in full medal premium (monthly, quarterly, semiannual and annual).

PEAT, MARWICK, MITCHELL & Co.,
CERTIFIED PUBLIC ACCOUNTANTS,
Chicago, Ill., July 7, 1971.

Re National Liberty Corporation File No. 2-33973

Mr. RICHARD Q. WENDT,
Actuary, Securities & Exchange Commission,
Washington, D.C.

DEAR MR. WENDT: Messrs. Weaver and Burns asked me to send you the raw data used in developing persistency rates for National Liberty and National Home guaranteed renewable health insurance. These persistency rates were used in calculating natural reserves for the December 31, 1970 financial statements of these companies (excluding a small block of health insurance issued directly out of St. Louis, Missouri).

The attached Xerox list of persistency rates was prepared by National Liberty personnel from in force tabulations of the above two companies developed in 1970. Persistency is summarized as follows (see Table 1):

1. Policy counts of in force at the beginning and end of durations;
 - a. By duration—meaning the first, second, third, fourth, fifth, and sixth policy years; and
 - b. By type of coverage within duration;
2. Cumulative persistency rates by duration for all coverages combined.

Crude rates were adjusted as follows:

[In percent]

Duration (1)	Cumulative persistency (2)	Crude lapse rate ¹ (3)	Adjusted lapse rate (4)
1.....	76.3	23.7	30
2.....	68.6	10.1	20
3.....	55.2	19.5	15
4.....	49.2	10.9	11

¹ Col. 3 equals 100 percent ((2)_t + (2)_{t-1}).

The adjusted lapse rates were used in calculating natural reserves.

Abe Hazelcorn and I graded the above rates into Linton B persistency levels for the fifth policy year and beyond. A copy of Linton B lapse rates is attached (see Table 2).

If you have any questions about these actuarial assumptions, please let me know.

Yours sincerely,

PEAT, MARWICK, MITCHELL & Co.

NORMAN E. HILL, FSA.

NEH:lb

Attachments.

TABLE 2

LINTON B LAPSE RATES

Policy Year:	Annual lapse rate in percent
1 -----	20
2 -----	12
3 -----	10
4 -----	8.8
5 -----	8
6 -----	7.2
7 -----	6.4
8 -----	5.8
9 -----	5.4
10 -----	5
11 -----	4.8
12 -----	4.6
13 -----	4.4
14 -----	4.2
15 and later-----	4

LYBRAND, ROSS BROS. & MONTGOMERY,

New York, N.Y., July 7, 1971.

Mr. RICHARD Q. WENDT,
Actuary, Securities & Exchange Commission,
Washington, D.C.

DEAR MR. WENDT: In our telephone conversation today, you inquired as to the effect of Medicare on lapsation, particularly since we have selected age 57 as a composite age in establishing an amortization schedule. We should make it quite clear that, although the eighth year might be a year of unusually high lapse for those policies actually issued at age 57 because of the effect of Medicare, the impact of Medicare should have no effect on policies issued to those already over age 65 since these individuals would clearly have decided that their coverage was needed despite the availability of Medicare; it would have no effect on those policies issued to those under age 45 since Medicare takes effect beyond the 20th year, which is beyond the point where our amortization schedule runs out.

We see, therefore, that the effect of Medicare might tend to increase lapse rates at durations 65-x for those policies within the issue range of 45 to 65. The lapse assumptions used were based on aggregate lapse experience by the company as it is currently experienced; the effect of Medicare is therefore built in to the lapse assumptions as we have selected them. The selection of age 57 is merely to get a proper average mortality effect on the schedule and it would be quite improper to assume higher than average lapses in the eighth year for the age 57 composite although it might be proper to use higher than average lapse experience for actual age 57 issue in order to determine the overall lapse rate.

We would now like to consider whether Medicare would have an adverse effect on lapse rates on any issue age. Most important in considering the effect of Medicare on the lapse experience at National Liberty is the fact that the coverage is supplementary in nature. Benefits are "add-on" cash benefits. I feel for one thing that there would be an analogous situation as with NSLI. The concern by some insurers in the early days of National Service Life Insurance was that it would be competitive and tend to replace commercial life insurance.

I think it can be safely stated that the insurance was considered supplementary and on the whole made GI's first aware of the need for life insurance after military service. Of course, as in the case of any body of policyholders, there will be some people who will take the insurance as a temporary measure. However, it is not expected that the existence of Medicare will create a tendency to drop out of the coverage once attaining age 65.

Also, it is important to state that the December 1970 exposure draft of the "Audits of Life Insurance Companies" requires that the assumptions, withdrawal among others, be in keeping with those used in the setting of the premiums. This is the case at National Liberty.

Apart from the audit guide condition for the assumptions was a separate look at experience which Mr. Hill and I made in order to arrive at the lapsation pattern. You should have received some material in this regard under separate cover.

Again, I would like to state that I am available, at your earliest convenience to assist you in expediting any actuarial matters you wish to discuss in regard to National Liberty.

Very truly yours,

LYBRAND, ROSS BROS. & MONTGOMERY,
By ABRAHAM HAZELCORN,
Fellow of the Society of Actuaries.

LYBRAND, ROSS BROS & MONTGOMERY,
New York, N.Y., July 27, 1971.

Mr. W. BENJAMIN WEAVER
*Treasurer, National Liberty Corp.,
20 Moores Road, Malvern, Pa.*

DEAR BEN: In accordance with your request, we are replying to the comments made by the SEC in their letter of July 22, 1971, page 7, second paragraph.

During the audit of National Liberty Life Insurance Company as of December 31, 1970, we examined the Company's actual acquisition costs incurred, and tested to see if the portion deferred was recoverable from future gross premiums. Our basic test involved the calculation of natural reserve premiums to see that these were no greater than gross premiums charged to policyholders.

Natural reserve premiums were calculated by us, based on principles and methods in Chapter 7 of the exposure draft of the Life Insurance Company Audit Guide (issued in December 1970). These premiums were the level amounts, calculated at issue, which were adequate to provide for all future benefits and expenses without profit margins. Acquisition and maintenance cost factors used in natural reserve premiums were set equal to actual 1970 unit expenses incurred.

In the attached exhibit, the following items are listed for health insurance plans sold by National Liberty:

(1) Acquisition and maintenance expenses per unit.

(2) Natural reserve premiums per unit, benefit portion, expense portion, and total.

(2) Gross premiums.

In each case, natural reserve premiums for National Liberty are less than corresponding gross premiums charged by the Company. As a result, based on the actuarial assumptions:

(1) Actual acquisition costs will be recoverable from future gross premiums.

(2) Profit margins exist in gross premiums charged.

In all our tests of National Liberty policies, we did not find any instances where natural reserve premiums were greater than gross premiums.

Please call if you need more information.

Sincerely yours.

ABRAHAM HAZELCORN.

EXHIBIT I.—NATIONAL LIBERTY EXAMINATION OF ACQUISITION COSTS INCURRED ON KEY HEALTH INSURANCE PLANS

Type	Expense unit	Premium unit	1st year unit acquisition and main- tenance expense (percent)	Projected renewal year unit main- tenance expense (percent)	Issue age	Projected natural reserve premiums per unit		Gross premiums per unit	Projected profit margin per unit	Percent of premium
						Benefit	Expense			
Guaranteed renewable hospital indemnity—male.	Percent of gross premium.	Per \$100 weekly hospital indemnity.	1 120.1	2 15.1	27	\$9.84	\$11.31	\$21.15	\$11.59	35.9
					37	13.60	11.27	28.87	8.13	14.6
					47	19.72	11.31	301.3	1.97	6.2
					57	28.49	16.23	44.72	3.35	7.1
					27	9.84	8.58	18.42	14.58	44.1
Guaranteed renewable hospital indemnity—female.	-----	-----	3 50.0	3 20.0	27	13.60	8.63	22.43	10.77	32.6
					37	19.72	8.74	28.46	4.54	13.3
					47	28.49	12.66	41.15	6.92	14.0
					57	35.51	11.31	24.82	3.18	24.0
					27	17.10	11.27	28.37	4.63	14.1
			1 120.1	2 15.1	37	21.05	11.31	32.32	4.64	1.9
					47	27.43	16.23	43.66	4.41	9.1
					57	35.51	8.58	22.09	10.91	33.0
					27	17.10	8.63	25.73	7.27	11.0
					37	21.05	8.74	29.79	3.21	9.1
			3 50.0	3 20.0	47	27.43	12.66	40.79	7.98	16.0
					57					

³ Based on commissions paid to DeMoss.¹ Based on actual unit acquisition expenses incurred in 1970 by DeMoss Associates, and affiliated agency.² Based on actual unit maintenance expenses incurred for individual guaranteed renewable health policies.

PEAT, MARWICK, MITCHELL & Co.,
Philadelphia, Pa., July 27, 1971.

Mr. W. BENJAMIN WEAVER,
Treasurer, National Liberty Corp.,
Moore's Road, Frazer, Pa.

DEAR BEN: In accordance with your request, we are replying to the comments made by the SEC in their letter of July 22, 1971, page 7, second paragraph.

In the course of our audit of National Home Life Assurance Company as of December 31, 1970, we examined the company's actual acquisition costs incurred, and tested to see if the portion deferred was recoverable from future gross premiums charged to policy holders. Our primary test involved calculating natural reserve premiums for life and health insurance to see that such premiums were less than gross premiums.

Natural reserve premiums were calculated according to principles in Chapter 7 of the exposure draft of the Audit Guide for life insurance companies issued by the AICPA on January 15, 1971. In essence, natural reserve premiums are the level amounts calculated at issue which are adequate to provide for all future benefits and expenses. In other words, a natural reserve premium is the projected "break even" premium. Acquisition and projected maintenance cost factors assumed in natural reserve premiums were set equal to actual unit expenses incurred in 1970. In addition to the acquisition and maintenance expenses, other actuarial assumptions used in natural reserve premium calculations, such as withdrawal rates, claim costs and interest factors have been discussed in our previous correspondence.

In the attached Exhibit 1, the following items are listed for certain key health insurance plans of National Home:

1. Unit acquisition and maintenance expenses used in natural reserve premium.
2. Unit natural reserve premiums with benefit portions kept separate from expense portions.
3. Unit gross premiums.

In every case you will see that natural reserve premiums of National Home are less than the company's gross premiums. This means that based on actuarial assumptions employed:

1. Actual acquisition costs incurred are recoverable from future gross premiums.
2. It is estimated that gross premiums include reasonable profit margins after full recovery of acquisition costs.

In all our tests of National Home policies, we found no material instances where natural reserve premiums exceeded gross premiums.

Please let me know if you require any additional information.

Very truly yours,

PEAT, MARWICK, MITCHELL & Co.,
NORMAN E. HILL, FSA.

AUGUST 6, 1971.

Re National Liberty Corp.

RALPH HOCKER, Esq.,
Associate Director, Division of Corporation Finance, Securities and Exchange
Commission, 500 N. Capitol Street, Washington, D.C.

DEAR Mr. HOCKER: We have been requested to furnish supplementally the derivation of the Company's lapse experience as shown in the table on page 6 of the prospectus, and to comment on any lapsation trends.

The development of the lapse rates used has been previously discussed in detail by Mr. Abraham Hazelcorn, the actuary from Lybrand, Ross Bros. & Montgomery, and Mr. Richard Wendt, the actuary for the Commission. This conversation was subsequently followed by a letter dated July 7, 1971 from Norman Hill, actuary for Peat, Marwick, Mitchell & Co. to Mr. Wendt. This letter explains the actuarial procedures used to develop the lapse percentages appearing in the table on page 6.

In order to review for discernible trends that might have developed with respect to the aforementioned lapse rates, the following information was developed.

[In percent]

End of year	Company's persistency by year of issue						Company's average persistency experience	Assumed composite	
	1965	1966	1967	1968	1969	1970		Persistency rate	Lapse rate
1.....	73.0	70.0	67.0	63.1	77.6	188.4	73.2	70.0	30.0
2.....	65.4	62.8	55.4	55.7	58.6		59.6	56.0	20.0
3.....	57.0	54.9	47.0	44.6			50.9	47.6	15.0
4.....	49.1	46.5	41.5				45.7	42.4	11.0
5.....	42.9	41.7					42.3	39.0	8.0

¹ Lapse rates for 1970 are favorably distorted by the timing of soliciting in 1970 whereby a large volume of policies was issued in November and December of that year. Such lapse rate would have been approximately doubled in 1970 were it not for the timing of this solicitation.

Although there have been fluctuations above and below the assumed rates, in general, no discernable trend has been noted in the most recent experience. Moreover, the above table indicates that in each of the five years, the Company's average experience is more favorable than the assumed composite rate utilized in computing yearly amortization.

Very truly yours,

W. BENJAMIN WEAVER.

Mr. SHARP. One of the critical actuarial assumptions would be the rate of policies terminated by the policyholders because they failed to renew them for various reasons, or because they die.

We have noticed a significant discrepancy between the termination rates supplied to the SEC in connection with a recent offering of your securities, and the termination rate supplied State insurance departments in connection with the rate filings for the NH-10, supplemental indemnity policy in question.

NATIONAL LIBERTY CORPORATION—COMPARISON OF TOTAL TERMINATION RATES FURNISHED IN SEC PROSPECTUS WITH THOSE GIVEN TO STATE INSURANCE DEPARTMENTS

[Percent]

Actuarial memo re policy NH 10-669					Actuarial memo re policy NH 10-669				
SEC data				Total termination rates	SEC data				Total termination rates
Age	Lapse rates	Death rate ¹	Total termination rate		Age	Lapse rates	Death rate ¹	Total termination rate	
57-----	30.0	1.4	31	28	67-----	4.8	3.1	8	13
58-----	20.0	1.5	22	18	68-----	4.6	3.3	8	13
59-----	15.0	1.6	17	15	69-----	4.4	3.6	8	13
60-----	11.0	1.8	13	12	70-----	4.2	3.9	8	13
61-----	8.0	1.9	10	11	71-----	4.0	4.2	8	13
62-----	7.2	2.1	9	12	72-----	4.0	4.5	9	14
63-----	6.4	2.3	9	12	73-----	4.0	4.9	9	14
64-----	5.8	2.4	8	12	74-----	4.0	5.3	9	14
65-----	5.4	2.6	8	12	75-----	4.0	5.8	10	14
66-----	5.0	2.8	8	12	76-----	4.0	6.3	10	14

¹ Total U.S. population 1959-61.

For the first 5 policy years these termination rates are similar. But thereafter for policy years 6 through 20, the termination rates supplied State insurance departments are much higher.

How do you explain this discrepancy between the data filed with the SEC and State insurance departments?

Mr. SLATER. I think the data filed with the SEC has to do with the method that we are using in writing off our acquisition costs and the rates filed with the insurance department are based on the experience that we anticipate.

Now we did make a substantial study last year and we redid all our assumptions and made extensive studies of persistency, and it could very well be that one was on one basis and the other one happens to be on the newer basis.

Mr. SHARP. Mr. Slater, could the reason be that the lower termination rates supplied to the SEC produce a better picture for your stockholders?

Whereas a higher termination rate supplied the State insurance department—

Mr. SLATER. I don't think that is necessarily so. How do you write off your acquisition costs?

Mr. SHARP. Pardon me, sir?

Mr. SLATER. The formula is how do you write off your acquisition costs. Now, the facts are that it is not going to make any difference over a period of years which one you use. The facts are going to come out, or the experience will be the one that shows.

Now what you have happened is that you have a formula for writing off your acquisition costs, and then the actual experience adjusts from year to year, as you go along.

Mr. SHARP. In the material furnished to the SEC in connection with the recent offering of your securities, particularly—the registration statement and prospectus—you gave the following projected profit margins for a \$400 hospital indemnity guaranteed renewable policy, that is, your NH-10 policy.

Now, I would like to read, Mr. Chairman, if I may, into the record:

At the issue age 37, the gross premium per unit, that is per policy, \$33 for males; projected profit margin, \$15.32 for that policy, and profit margin as a percent of premium, 46.6 percent.

Again, for males at age 47, the gross premium per unit, \$36.00; projected profit margin for this \$400 hospital indemnity policy, is \$13.60. Profit margin as a percent of premium, 37.8 percent.

Fifty-seven-year-old males, and age 57 is the average age of the people who buy your policy according to the information furnished to the SEC, the gross premium is \$47.50; the projected profit margin per unit was \$18.47; the profit margin was 38.9 percent.

For females, age 37, \$33 gross premium; projected profit margin per policy, \$12.71; 38.5 percent projected profit margin as percent of premium.

Forty-seven-year-old female, \$36 gross premium per unit; projected profit margin per unit, \$12.49; profit margin as percent of premium, 34.7 percent.

For a 57-year-old female, \$47.50 gross premium per policy here; projected profit margin per unit, \$18.96; profit margin for percent of premium, 39.9.

What is your reaction to this? It seems like a very high profit margin to expect here on these policies.

Mr. SLATER. Are you sure those figures are not before acquisition costs?

Mr. SHARP. No; these are after acquisition costs, sir.

Mr. SLATER. We don't seem to have those figures. Now we did give you our figures of what we expected—where out of a hundred and two percent, which would be premiums and investments, [and] there would be a profit margin of about 10 percent of premium.

Now this profit, this 10.5 is a double profit margin. It is not a single one. It is a marketing profit plus a carrier profit.

I think most of the figures you have seen are not where you would have two different profit margins. This is one—this is two. You generally just see one.

Mr. SHARP. May I give you this table? Thank you, sir.

(Table follows:)

EXHIBIT 1. NATIONAL HOME EXAMINATION OF ACQUISITION COSTS INCURRED ON KEY HEALTH INSURANCE PLANS

Plan	Type ¹	Expense unit	Percent of gross premium.	1st year unit acquisition and maintenance expense (percent)	Projected renewal expense (percent)	Issue age	Premium unit	Projected natural reserve premiums per unit			Gross premiums per unit	Projected profit margin per unit	Percent of premium
								Benefit ²	Expense	Total ³			
N.H. 10-669	Hospital indemnity guaranteed renewable for life, male			120.1	15.1	27	Per \$400 monthly hospital indemnity.	6.43	12.19	18.62	33.00	14.38	43.6
	Hospital indemnity guaranteed renewable for life, female.			120.1	15.1	27		9.05	12.17	21.22	33.00	11.78	35.7
				50	20	37		8.79	12.14	20.93	33.00	12.07	36.6
				50	20	47		12.60	9.80	22.40	36.00	13.60	37.8
				50	20	57		16.16	8.85	17.68	33.00	15.32	46.4
				50	20	57		16.16	12.87	29.03	47.50	18.47	38.9
				50	20	37		11.40	12.14	23.54	33.00	9.46	28.7
				50	20	47		13.71	13.28	26.99	36.00	9.01	25.0

¹ Since the majority of business income and deferred acquisition cost of National Home represents guaranteed renewable health insurance, life insurance plans are not included in the exhibit.

² Equivalent to the gross unearned premium plus additional margins for increased claim costs resulting from the guaranteed renewable feature.

³ As set forth in the attached letter, the total natural reserve premium is the projected "break even" premium.

⁴ Based on actual maintenance expenses incurred for individual health insurance by National Liberty Life Insurance Co., an affiliated life insurance company.

⁵ Based on commission rates paid in 1970 to DeMoss Associates.

⁶ Based on actual unit acquisition expenses incurred in 1970 by DeMoss Associates; an affiliated agency.

Mr. SLATER. We'll come back to this if you don't mind. I'll let Mr. Patty take a look at it and then we'll come back to it.

Mr. SHARP. We'll welcome an explanation, if you would care to furnish one later for the record.

Mr. SLATER. I don't think it's giving the impression of the facts. The facts are not the impression that you've taken from it, and as I look at it, I get the same impression as you do, but I'd like to examine the figures a little before.

I think the overall summary we gave you on profits is probably more accurate.

Mr. SHARP. Well, sir, what do you feel the profit margin is?

Mr. SLATER. Well, last evening I read an article by Martin Ginsborough of the National Industrial Conference Board and he said that manufacturing companies had a profit of 4 percent after taxes. Now, that is a profit of manufacturing.

Mr. SHARP. Four percent after taxes, is that on sales?

Mr. SLATER. Four percent of sales after taxes, that's correct.

Mr. SHARP. Have you any idea what that would be as far as net worth?

Mr. SLATER. This is an average taking people of all——

Mr. SHARP. That says sales. I'm talking about after you take the surplus——

Mr. CHUMBRIS. He is quoting Ginsborough. You are asking him to speculate on what Dr. Ginsborough has revealed.

Mr. SLATER. Taking that as a benchmark, and working from there that he said 4 percent of sales after taxes.

Mr. SHARP. I'm sorry for interrupting you. Go ahead.

Mr. SLATER. If you go ahead. If you look at the figures we have presented to you, somewhere between 7 and 10, remember, this is a double profit margin and not a single one such as we have referred to.

Now, if you are going to compare us, say, with General Motors, you would have to take the profit of General Motors plus the profit of the dealers to compare to this 7.25 to 10 percent that we have here, because we are the marketer and we are also the carrier.

Mr. SHARP. Sir, would you have any idea what the average rate of return on net worth is? That is, take the assets minus the liabilities and that's what this——

Mr. SLATER. Are you talking about our company?

Mr. SHARP. Not in your company, sir. I mean on the average for, let us say, manufacturers?

Mr. SHARP. I would say most manufacturing companies are looking for 25-percent return on their money.

Mr. SHARP. Twenty-five percent of return after taxes?

Mr. CHUMBRIS. Mr. Sharp is bringing up the point that has been disputed within this subcommittee for the last 15 years, and that is how to determine profit, whether it is on sales, whether it is on net worth, and several other theories, and it all depends upon what industry we are talking about.

We have had witnesses who have testified, for instance, grocery stores and national chains, they say that 1 percent on sales, they are doing very well. Whereas, some companies have to make 6 percent on sales to be able to survive and meet their stockholders obligation.

Others have to make maybe 10 percent because their turnover is not as fast as the 6 percent or the 1 percent industries.

There are so many conflicting theories for us to get into discussion on this matter. Unless there is a specific reason to point up which theory we want to use, I think that we are asking the wrong questions of the wrong witness.

Mr. SLATER. We are talking about something between 20 and 30 percent.

Mr. CHUMBRIS. Your return on investments.

Mr. SHARP. We have noticed from the latest prospectus filed with the SEC, you made \$12 million, after taxes, on your net worth of \$44 million in 1970. This means National Liberty had a 27-percent return after taxes in 1970. That's close to the 20 or 30 percent.

Don't you think that this 27 percent return is excessive compared with A.T. & T.'s 9 percent return after taxes in 1970? The Chase Manhattan Bank had a 10.8 percent after tax return on net worth in 1970. Both are in regulated industries, as I assume your company is.

Mr. SLATER. Well, I think there is a lot of difference here, Mr. Sharp. You are talking about A.T. & T., which is a mature business. Remember that you are talking about a company that, in 1971, wrote more business than it did in, I think, the prior 5 or 6 years, and that we know that the profit rate on new business is much higher than the profit rate on mature business.

If you are going to compare us with the Chase Manhattan Bank, which is a mature organization of over 100 years of age, which has a lot of old business on the books; we have proportionally a lot of new business on the books, and whenever you have a new product, the rate of return is always higher.

And we do not anticipate, as our company matures, that our profits will remain anything like what you are referring to.

Mr. SHARP. I wonder if we could move on to an area that was earlier commented on by the chairman and Mr. O'Leary: the advertising practices of your company.

You are aware—and I hope I am quoting correctly and please correct me if I am wrong—I understand the Louisville Courier Journal and the Toledo, Ohio, Blade, have refused to carry mail order health insurance advertising. Are you aware of this?

Mr. SLATER. The Louisville paper—I don't know the name of it myself—has said that for a temporary period they were suspending advertising so that they could devise the proper guidelines for the basis on which they would receive advertising.

We have seen those guidelines and our advertising conforms to it and as soon as they say OK we will be back in the newspaper.

Mr. SHARP. It is our understanding, also, that Mr. Art Linkletter has a \$50,000-a-year contract with your company, is this true?

Mr. SLATER. Mr. Linkletter has a \$50,000-a-year contract with our company, yes.

Mr. SHARP. Does this appear in your advertising brochure?—the fact that Mr. Linkletter has a contract with your company or is just his picture in there?

Mr. SLATER. No, it does not. I have never seen any other endorsement that does.

Mr. SHARP. Are there any other such endorsements in this field, such as this?

Mr. SLATER. Mr. Harvey endorses for the Bankers Life & Casualty, that appeared here the last time. Jack Benny endorses. There is another, Fenneman, a TV personality, also endorses.

Let me point out to you, Mr. Sharp, that Mr. Linkletter has made over 100 commercials for TV advertising, and if you take the \$50,000 and divide it into that, that is \$500 a TV ad, and that is relatively inexpensive.

He is a member of the board, he serves as a marketing consultant, and we think we are getting him for a very cheap price. We do put in our advertisements that he is a member of the board.

Mr. SHARP. You do. I notice that in your National Liberty Corporation Annual Report, there is listed an Andrew Heiskell, who is he connected with, sir?

Mr. SLATER. He is connected with National Liberty Corp.

Mr. SHARP. Are there any other businesses that he is connected with?

Mr. SLATER. Not to my knowledge. He is a full-time employee of National Liberty Corp.

Mr. SHARP. As director and officer, you also have listed here Wallace Ericson, president, Wallace Ericson Co., Chicago, Ill. What is his function as a director with your company?

Mr. SLATER. Well, he is an outside director of the company and has been an outside director ever since the company has gone public.

Mr. SHARP. Do you know what his business connections are?

Mr. SLATER. He is a scientist and I'm not sure what field he is in.

Mr. SHARP. And you have W. Marvin Watson listed. President, Occidental International Corp.; former Postmaster General of the United States. Any particular reason that he is serving on your board of directors?

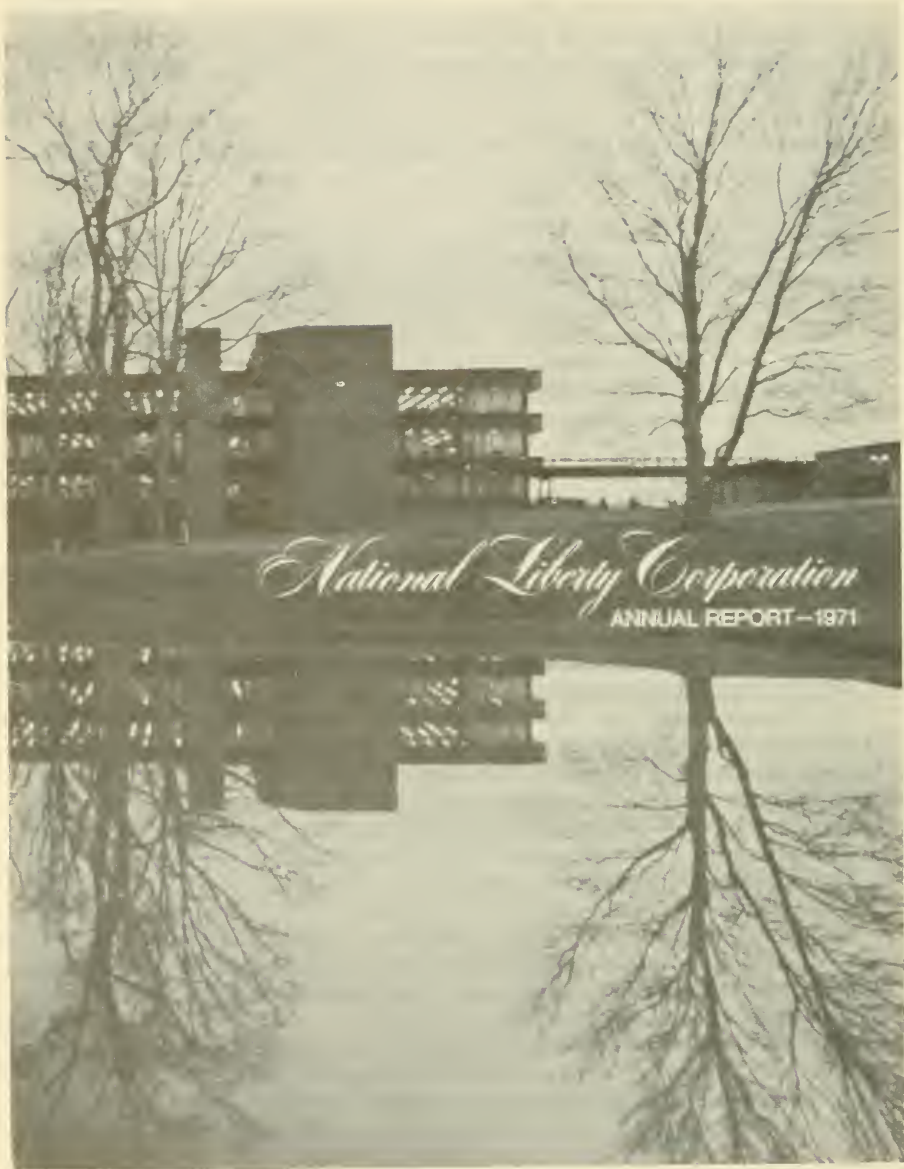
Mr. SLATER. We like to have outside members on the board to get their advice and I might say that they all attend every meeting.

Mr. SHARP. Any particular reason why Mr. Frank Carlson serves on your board?

Mr. SLATER. Well he is a man that can give us particular advice in a lot of areas and we welcome that advice. Senator Carlson, as you know, is now an elderly gentleman. He has retired from the Senate and attends our meetings faithfully.

Mr. SHARP. I would like to introduce into the record, Mr. Chairman, the National Liberty Corporation 1971 Annual Report.

(Documents follow. Testimony resumes on p. 662.)



National Liberty Corporation
ANNUAL REPORT—1971

We of National Liberty Corporation believe it is incumbent on us and the best possible stewards of the God-given resources entrusted to us—time, talent, and means.

We recognize obligations to various groups of people—policyholders, shareholders and personnel. But our first and foremost obligation is to God. Our objectives and methods must, therefore, be in conformity with the teachings of Scripture.

We want to render a positive Christian testimony and be a constructive force for good in all that we do in relation to our community, our state, our nation, and to the business of the world at large.

To our policyholders we wish to render the best service possible at all times, so that good service is both a fact and a philosophy and a reality. This would include the payment of claims as promptly and equitably as is humanly possible.

Insofar as our people are concerned, we must constantly endeavor to fit each position with the best possible person for that particular job. Every individual must be given opportunity to optimize his talents and abilities to make the maximum contribution possible and receive maximum compensation in personal job satisfaction, self-realization and self-fulfillment. Creativity and responsible innovation must always be encouraged and rewarded.

We believe that National Liberty Corporation, when rooted in these convictions, will, with God's favor, inevitably benefit all parties—policyholders, shareholders, and our personnel.



*Philosophy
of National
Liberty
Corporation*

Highlights of the Year

Comparative Highlights	1971	1970	Percentage Increase
Assets:	\$190,207,705	\$124,090,811	53.3%
Shareholders' Equity:	75,063,436	44,147,088	70.0%
Insurance Premiums:	76,967,280	53,951,197	42.7%
Investment Income:	3,669,909	2,694,355	36.2%
Total Revenues:	84,812,859	59,535,030	42.5%
Net earnings before investment losses and extraordinary items:	14,151,041	9,169,318	54.3%
Net Earnings: (a)	13,845,193	11,840,096	16.9%
Net Earnings Per Share before investment losses and extraordinary items:	\$1.56	\$1.04	50.0%
Adjusted Average Number of Shares Outstanding:	9,074,399	8,907,178	

(a) Net earnings include non-recurring items described more fully in the Consolidated Statement of Income. Net earnings per share after non-recurring items were \$1.53 in 1971 and \$1.34 in 1970.

The above highlights are shown as prepared in accordance with accounting principles as set forth in the exposure draft of Audits of Life Insurance Companies, released by the American Institute of Certified Public Accountants in December, 1970.

Robert E. Slater

Chairman's Message

When I was elected Chairman of the Board of National Liberty Corporation, I received several inquiries asking me to spell out the difference between operating a giant life insurance company, which I did for some time, and the companies in the National Liberty Group. The difference is that which distinguishes *being* a leader from *becoming* a leader, in any field. I have no doubt that National Liberty is becoming one of the giants of the financial world, for we have evolved a scientific approach to marketing which enables us to generate profitable new business at an unprecedented rate while providing a useful service to society.

At National Liberty we are exploiting every available means of reaching literally millions of people through unique, low-cost, methods of market identification and new product development. We do this through the application of actuarially sound market testing methods. This enables us to develop reliable indicators of public preference for the variety of products which the company can offer.

When I became a Director of National Liberty Corporation two years ago, I was certain that traditional methods of marketing insurance could be improved upon. Now that I have changed my posture from observer to participant, I am even further convinced I was right. National Liberty, through the success of its unique approach to marketing, has provided such an improvement. Premium income on new, individual health and accident and life insurance policies compares favorably with the volume of similar new business produced by the industry's largest companies.

The price of success in any field is increased competition. Our competitors have confirmed the soundness of our marketing methods. We have, in effect, helped to create a new industry—supplemental health insurance—in which National Liberty is the acknowledged leader.

How broad the market is remains anybody's guess. Interestingly enough, our period of greatest growth occurred

while the nation's economy was seriously depressed, when people were banking their money rather than making purchases. We can only estimate what a stable economy will mean in terms of the growth of your company. However, even a stable economy, coupled with a reduction in the unemployment rate, will not cause a decrease in cost of hospital care. We believe that these factors will provide an increasingly receptive market for our supplemental accident and health coverages in the future.

As the person responsible for the day-by-day operations of National Liberty Corporation, I am highly enthusiastic about its prospects for the future. But the future cannot be left to develop by itself. At National Liberty we place great emphasis on advance planning. We have well-defined plans for the 1970 decade, indicating where we want to go and how we want to get there. I am pleased to note that although we are just entering 1972, we are already ahead of our planning in terms of both goals and objectives.



Fellow, Society of Actuaries, Chairman of the Board of Directors and Chief Operating Officer

Although the financial figures contained within this Annual Report speak extremely well for the company, I believe the true wealth of this organization lies in the unique talents, energies and ideas of the many men and women who carry out the myriad complex tasks which sustain the tremendous momentum this organization has been able to generate.

Robert Slater
Robert E. Slater

Arthur J. DeMoss

President's Message



Founder, President and Chief Executive Officer

1971 marked the twelfth consecutive year of growth in profits and earnings for your company. Revenues at \$84,812,859 were up 42.3%, net profits at \$14,151,041, were up 54.3%. Earnings per share at \$1.56 were up 50%.

"How long can you keep this up?" is the question we are often asked. We can give no specific answer except to say that we see no end in sight.

Growth in a company like ours doesn't just happen. It is caused by the dedicated and concerted efforts of a great group of people. And the attitude of these people toward our record for 1971 can be summed up this way: "We are gratified, but not satisfied." Once self-satisfaction creeps into any business, apathy and stagnation follow.

Behind the statistics which you will find in this report, there are many factors which helped to produce them. First of all, I want to reiterate my firm conviction that a company is only as good as its people. During the year 1971 we attracted unusually talented and dedicated people at every level.

Heading the list, of course, is Robert E. Slater, a brilliant actuary who worked his way up through the ranks to head the John Hancock Mutual Life Insurance Company. Mr. Slater, who is 55, long has been a keen student of the business. His experience in directing thousands of people and in the deployment of billions of dollars in assets has already proven to be of significant value to us. Before joining National Liberty, but while he served as a Director, Mr. Slater spent a year abroad, during which he gained an insight into international marketing which will be particularly useful as we expand worldwide.

We are also pleased to welcome Robert O. Safford as Executive Vice President—Sales for National Liberty Corporation. I have personally admired Mr. Safford's competence and enthusiasm for several years. These qualities have enabled him to compile a highly enviable record in life agency sales management. His personal and corporate sales records have made him well known and respected throughout the insurance industry. Mr. Safford has been charged with building a national specialty sales organization which we will be able to tell you more about later in the year.

Toward the end of 1971 we added to our Board of Directors a man whose

name and face are so well known that his identification with National Liberty brought immediate and enthusiastic response. Art Linkletter's familiar features now grace much of our print and TV advertising.

Mr. Linkletter has added to the element of believability which is so important when there is no personal contact between the company and the prospective policyowner. Undoubtedly, one of the reasons for Mr. Linkletter's success is that he is not just a television personality, but a real man with keen intellect and a great heart. He contributes to our Board discussions not as an entertainer, but as an outstanding and successful businessman.

Also enriching our Board during 1971 was David H. Jaquith, Chairman of the Board of Vega Industries, Syracuse, New York. Mr. Jaquith is a Fellow of the American Management Association, a Director and a Member of the Executive Committee of the AMA and is Chairman of that organization's Presidents Association. He brings to NLC a wealth of management experience.

At the November Board meeting it was announced that William W. Scranton had been appointed to the President's Price Commission. As a result, Governor Scranton, to avoid any semblance of conflict of interest, resigned as Chairman and as a Director of National Liberty Corporation. Our association with him has been so enjoyable that we would genuinely regret losing his services were it not for our conviction that his contribution to our country's welfare supersedes any commercial considerations.

In February 1971, after many years of planning and waiting, we moved into our new home office building, located on 92 acres of land through which marched the troops of General Washington on their way to neighboring Valley Forge.

Our original plans called for a second building, adjacent, to be built in 1974, but the tremendous growth of the company has forced us to move the schedule ahead. The second unit will house an additional 750 people when completed in early 1973.

We have estimated that National Liberty could sustain a growth rate of 20-25% per year without the need to

seek outside funds. We believe, however, that we should reach out to the limit of our ability to maintain growth far beyond what is simply convenient.

The successful offering of National Liberty stock in September 1971 at a price of \$36.50 a share, added \$17 million to the Corporation's resources. In addition, the commercial banks with which we do business have indicated their willingness to continue to make available sufficient financing, when, if and as needed.

If I were asked to give a simple explanation of how we do things at National Liberty, I would express it in a three word formula: "Research—Test—Explode!" We are continually looking for and researching new marketing ideas, products, media, concepts. When we find them we put them to the test. When a test empirically demonstrates that we have another "winner," we then explode it with all the resources at our command.

During the year we were pleased to receive numerous visitors. We always enjoy taking them through the building and providing an overview of our operations. Since all shareholders cannot possibly visit us, we will take you on a simulated tour through the medium of the pages of this report.

Aside from the gifted people who have joined National Liberty in the past twelve years, the financial resources which have been available to us, and the successful implementation of many new ideas which have set us apart from other companies, we have what we call a "secret weapon" which we employ regularly in our operations. To us, the slogan "In God We Trust" which appears on our coins is not simply a pious platitude but a practical reality. We believe in prayer not merely as a religious exercise, but as a vital force available to us as individuals and doubly effective as a means of welding together people who work together. We have many policyowners and shareholders who write to tell us that they pray for us, and for this we are grateful.

As always, we welcome questions or visits from our shareholders.



Arthur S. De Moss

A Trip Through National Liberty

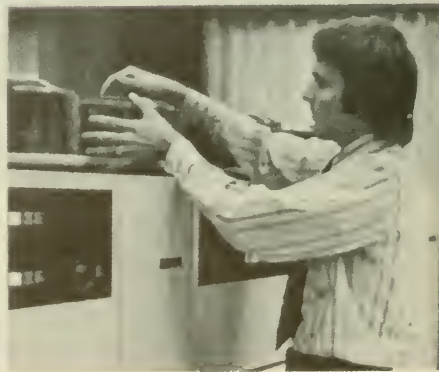
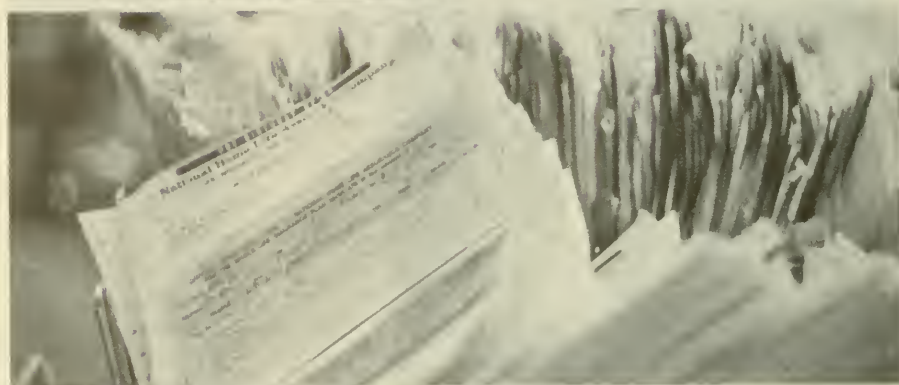
As you enter the impressive lobby of the new National Liberty building, you are greeted by our receptionist. Upon informing her that you have been promised a guided tour, she summons one of our hostesses.

As you sign the guest register, the hostess explains that National Liberty Corporation is made up of five major subsidiary companies, De Moss Associates, National Liberty Life Insurance Company, National Home Life Assurance Company, National Information Systems Corporation, and National Consumer Marketing Corporation.

"We'll start with the oldest, our marketing arm, De Moss Associates. Won't you please come with me."

Of course, it is not possible for every visitor to have the opportunity to meet each company president. Were that possible, the following pages highlight what they might be likely to tell you.





"Mr. Shipley, president of De Moss Associates, came to National Liberty after 14 years with Procter & Gamble, one of the world's great marketing organizations."

De Moss Associates Inc.



*William H. Shipley
President, De Moss Associates, Inc.*

"Welcome to De Moss Associates," says Shipley, with a disarming smile. "I imagine you would like to know how we obtain the direct response business which provides the 'fuel' to run this whole Corporation. Well, let me start back in 1959 when Arthur De Moss formed De Moss Associates. Until that time, direct response advertising efforts in the accident and health field had been sporadic at best. Little had been accomplished by anyone in this area. Mr. De Moss, as an enterprising marketing man, took the lead. He started selling health insurance directly to the abstainer market, and soon became the outstanding direct response marketer in the country. As a result, our business grew at a very rapid pace. It is through his efforts that De Moss Associates has developed into a direct response marketing company.

"Basically our company today is doing the same sort of thing that it did then, but on a much larger scale and in a more sophisticated manner. In 1971 our advertisements appeared more than 750 million times. They ran in virtually all of the leading newspapers of America: some as full page advertisements; others as free-fall inserts. In addition, ads were run in broad circulation magazines and specialty newspapers. We mailed more than one hundred million direct mail solicitations. These mailing pieces, as well as our other advertisements, were to both the Gold Star (abstainer) market and the broad market, which includes all people.

"De Moss Associates has become one of the finest marketing companies in America by carefully selecting personnel with backgrounds and strengths that complement and *add* to the direct response business. We have built a team of young managers (average age under 37) who are not necessarily from the direct response industry, but who are experts in their individual marketing areas. As a result of the efforts of these people, our business has rapidly grown through the use of creative newspaper and magazine advertising, new forms of direct mail, a unique approach to television and radio and by expansion into international markets.

"Sophistication continues to develop not only in the classical marketing sense but also in a financial sense. For the past 12 years, we have kept careful records on all response patterns, persistency statistics and claim payments. This information has been incorporated in a sophisticated computer program which provides us with

Effective March 15, 1972, the name of De Moss Associates, Inc. was changed to National Liberty Marketing, Inc., in keeping with the pattern established by other National Liberty subsidiaries.



Creativity plays an important role



Phone inquiries are handled promptly



Computer reports aid planning

a 'media profile.' This quantifies such elements as type of publication, place of residence and method of marketing. Availability of this kind of information allows us to predict accurately the return we can expect from each dollar invested in marketing activities. We have been able to rank these activities so that our investment is made only in those activities which will give us the maximum return for minimum investment. Constant refinement of the 'media profile' provides ever greater reliability.

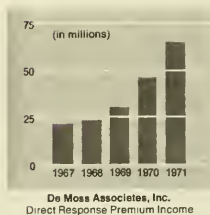
"Market tests and research programs have been conducted in several countries. We have spent many dollars in determining the make-up of the international market, and to evaluate the potential market for direct response insurance overseas. We have found that our type of supplementary coverage for hospitalization, convalescence, and accidents as well as life insurance, is in demand in many foreign countries, even those with nationalized health schemes.

"To develop a business as large as De Moss Associates, one that is growing as rapidly as ours has, we have found it advantageous to have our own Creative Services Division. We have copywriters, artists and other creative people working on our business on a daily basis. It is their job to make sure that our advertising materials conform to the laws and regulations of the various state and international insurance departments and that we are constantly informing our policyowners, in the simplest manner possible, what their policy offers them.

"Once we sell a policy, we consider service to be as important as the original sales effort. Therefore, we have a special Policyowner Marketing Division which, through telephone lines covering the entire country, provides personal service on claims, helps straighten out problems, and offers additional coverages to our policyowners. These people are available to service our policyowners 16 hours each day, five days a week, plus a half day on Saturday.

"Today, De Moss Associates has over 170 full-time employees marketing direct response life accident and health business for National Liberty Corporation.

"And that, considerably simplified, is how we do it," Shipley concludes. Turning to your hostess he suggests, "Perhaps our guest should now find out what happens once the policy has been sold."



"Mr. Keller knows the administrative side of the insurance business inside out. He's obtained amazing results in getting policies issued and claims paid quickly."

Meeting John Keller, President of National Liberty Life, you inquire what happens to policies once they've been sold. He responds by telling you that National Liberty Life issues the policies from all direct response advertising, collects the premiums, and pays the claims.

Your tour of National Liberty Life begins in the mail department. Literally thousands of pieces of mail are opened and sorted here before being routed to an area on the third floor where cash and checks are extracted and applications are neatly bundled. Each bundle has a processing control tag for recording the elapsed time at various work stations.

National Liberty Life Insurance Company



John W. Keller
President, National Liberty Life Insurance Company

"The objective is to assure delivery of the policy, in the shortest time possible, to every person whose application is approved. During 1971 we reduced what we call the 'turnaround time' from an average of 8 days to an average of 2½ days. This means that a person who has responded to our advertising gets a taste of what our service is like by receiving his policy in an astonishingly brief period of time. Thus he knows he is an important person to the company and will receive the same kind of service should the time come for him to file a claim.

"Since we quite often process more than 100,000 applications in a single month, we have had to develop systems and controls to keep things flowing smoothly and on time. It is not difficult to imagine the mountainous backlogs we'd have if all that paper started piling up. We use a highly skilled systems staff which keeps monitoring our performance and reporting results to all levels of management for any needed corrective action.

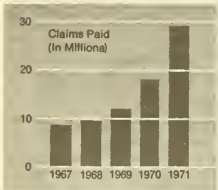
"I am especially proud of the performance of our Claim Division in expediting the payment of benefits to policyowners. We are currently paying approximately 1,000 claims per day. The majority of these are mailed out in less than a week. Our attitude in claim handling is that policyowners, who have entrusted us with their policy premiums, deserve prompt consideration. To this end we have written a statement of philosophy to be followed by our claim examining staff as part of their job requirement. This statement, among other things, clearly declares that every covered claim is to be paid in the shortest time possible. As in policy issuance, our systems and controls assure a smooth and timely flow of each claim from receipt to settlement.

"In August, 1971, we launched a new and wholly-owned subsidiary, National Home Assurance Company of New York. It actually began operations in November and in its first two months, more than 17,000 policies were sold.

"National Liberty Life services all of the direct response business for its own policyowners, for those of National Home Assurance of New York, and those of its sister company, National Home Life Assurance Company," Keller states. "I hope you'll be seeing the people of National Home Life to get their story as well."



National Liberty Life Insurance Company
Direct Response



National Liberty Life Insurance Company
Direct Response



Over 1,600,000 policyowners

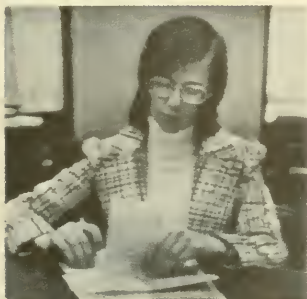
It all begins in the mail room



Checking policy information



Organization is the key



Date and day tags speed processing



Creating order out of potential chaos

"If you'll come with me down to the second floor, I'll be happy to introduce you to T. Robert Wilcox, President of National Home Life Assurance Company, who will give you some idea of how his operations differ from those of National Liberty Life."

"National Home, to many people, is the best-known of our companies. As the underwriter of most policies, its name is the one you see in our advertising programs."

"When National Liberty purchased National Home in 1969," Wilcox explains, "they acquired a company that was about 50 years old and had on its books agency-produced business in both the life and accident and health fields. In addition, they gained experience, and an agency force capable of selling both life and health and accident policies."

"In the short space of three years, National Home's operations have been smoothly integrated with those of the other companies in the National Liberty complex. Right now, for instance, we are in the process of converting our computer program, under the direction of National Information Systems."

"In July 1971, we moved our administrative offices from St. Louis to the home office of National Liberty, to enjoy the advantages of proximity to the service facilities of our parent company. This move has already resulted in a considerable saving in overhead, and, we believe, in the quality of our service."

"From a financial standpoint, premiums earned in National Home Life during 1971 reached almost \$52,000,000. Admitted assets rose to \$42,495,413 and capital and surplus amounted to \$9,928,610. A substantial portion of the premiums was, of course, direct response business produced by De Moss Associates, Inc."

"On the other hand, during 1971 we developed many new products and increased the flow of agency-produced business by more than 100%. We have over 4,000 agents in the field. However, by dealing directly with large general agencies and eliminating the need for an extensive in-house agency department, we are able to keep our new

National Home Life Assurance Company

*T. Robert Wilcox
President, National Home Life Assurance Company*



National Home—Average size of life insurance policies written through agents

business acquisition costs extremely low. The agencies we deal with are basically in the estate and total financial planning areas of the life insurance industry.

"Life insurance issued during 1971 amounted to approximately \$212,000,000. The average size life insurance policy sold by our agents was approximately \$70,000. We believe this is probably the highest average of any company in the insurance industry.

"Although National Liberty is well-known as a direct response marketing organization, we believe that there is now and will remain a definite need for agents to assist policyowners in some of the more complex aspects of financial planning relating to insurance and investments.

"I am sure that you must be thinking by now that a company which deals with thousands of policies, both life and health and accident, which works with a field force and direct response advertising as well, must have a terrible problem keeping it all straight. Well, in addition to the tremendous services provided by John Keller's people in National Liberty Life, which you've already visited, I'm happy to tell you that one of the real saving graces of this organization is the support which we have received from National Information Systems Corporation.

"By the way, in case you hadn't planned it, I urge you to take a look at that operation," Wilcox suggests. "It is as contemporary in its facilities and service capabilities as anything available. You'll find them on the same floor we are, at the other end of the building."



National Home
Total Premium Income
Life ■ A & H ■

"The National Information Systems facilities center may remind you of pictures you've seen of the glassed-in 'clean rooms' at the space center in Houston or Cape Kennedy."

The large, colorful room you now enter appears to be dust-free and organized to the maximum. It presents the appearance of a complex interaction of electronic components, absolutely under control. President Carl G. Sempier, a man of infectious enthusiasm, greets you.

National Information Systems Corporation

"I suppose I should tell you right away that what you see here today is just part of our total complex. We also have operations and equipment at locations in Haddonfield, New Jersey; Rosslyn, Virginia; Chicago, Illinois; Dallas, Texas; and Toronto, Canada.

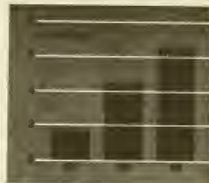
"Further, although we primarily serve National Liberty and its various components, we have branched out and today serve a number of other industries as well.

"NIS equipment, which you see here, includes a new IBM 370 system as well as the IBM Model 360/40. The equipment is used around the clock. Millions of transactions are processed each month for National Liberty Life and National Home Life.

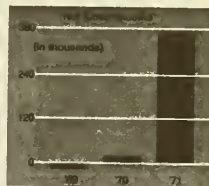
"Perhaps one of the most fascinating features," he explains, "is that a policyowner can call in to inquire about his policy, and his records will be available from the computer in a matter of just seconds.

"Now, in terms of where we are and what we're doing," Sempier continues, "let me explain that our growth has been largely in two areas, financial and capabilities.

"From a financial performance viewpoint, NIS gross revenues increased to \$6,489,132 from \$4,622,969. Income from operations increased to \$359,851 from \$16,123 or \$.09 per share compared with \$.004 for 1970. The 1970 financial results have been restated to include the acquisition of Computer Investments and Leasing Corporation which was acquired during 1971 and accounted for on a "pooling of interests" basis. In 1971, an extraordi-



National Information Systems
Revenue
From Affiliates ■ From Non-Affiliates ■



National Information Systems
Income Before Extraordinary Items



*Carl G. Sempier
President, National Information
Systems Corporation*



The new IBM 370/40 increases capabilities



Project board at the Data Center

nary charge primarily resulting from the revaluation of the 'Goodwill' associated with the acquisition of Mastech Computer Systems, Inc. reduced earnings per share from operations from \$.09 to a loss of \$.04.

As if reading your mind, Sempier suggests with a smile, "I'll bet you're wondering how a company like ours grows in terms of capabilities. Well, in 1971 this kind of growth took five forms.

"First, was product performance. This is excelling in what we do and within an industry specialty. Our field of greatest expertise—I believe it to be unparalleled—is in support of the insurance and direct response marketing industries.

"Second, we branched out to serve new industries such as commercial banking, mutual funds, and State and Federal Government processing. I believe we have real potential for future growth in these areas.

"Third is in terms of growth of our own personnel. Today we employ over 275 incentive-oriented, innovative, youthful and aggressive information specialists.

"Fourth is the creation of NIS, Ltd. of Canada. Here we have contracts under negotiation with an insurance company and a mutual fund which should provide us with a profitable base for operations in that country.

"And fifth is in a variety of new products. During 1971 we developed four new software packages and two additional systems which considerably enlarge our capabilities.

"Another point which I believe should be mentioned is the acquisition, in December 1971, of Computer Investments and Leasing Corporation, which significantly increases our capacity to handle additional business and the opportunity for future growth.

"Finally, I have to say that being a part of NIS is a terribly exciting thing. Most of our people have been with much larger companies in the past, but I believe they would subscribe to the philosophy which Mr. Slater, National Liberty's Chairman, advances when he talks about the difference between being and becoming. If you've ever been in an athletic event, you know that the real thrill is in the doing.

"Well, I hope I've been able to give you some idea of how NIS fits into the scheme of things at National Liberty. Call us anytime if you have any questions."

After lunch in the attractive employees' dining room, overlooking a spring-fed pond and stream where a family of ducks make their permanent home, you are escorted to the headquarters of National Consumer Marketing Corporation in King of Prussia, just a few miles distant.

"Although its field is marketing, this is possibly our most diversified subsidiary company. They always seem to be working with some new and exciting idea," your hostess observes.

"National Consumer Marketing is a natural adjunct to the operations of National Liberty Corporation," says Charles M. Cavanagh, NCM president.

National Consumer Marketing Corporation

Charles M. Cavanagh

President, National Consumer Marketing Corporation



Access to 100 million names



Planning TV time purchasing



Publishing the annual and quarterly Family Album



"We believe the marketing techniques which National Liberty has used so successfully in the insurance business are just as applicable to many other products and services.

"Our company is organized into three operating units—National Media Services, Valley Forge Associates and the Creative Services Division.

"In National Media Services during 1971 we devised several new techniques in the printing of newspaper inserts and in direct mail which have already resulted in substantial savings to De Moss Associates and which have application to companies outside the National Liberty Group. In addition, in this unit, we have built a highly professional and efficient TV spot buying organization to service members of the National Liberty Group and also outside clients.

"At Valley Forge Associates in the past year we have developed a strong expertise and management team in the area of mailing lists used primarily at this point for De Moss Associates, but which, during 1972, will be expanded to additional clients outside the National Liberty Group. This area of activity handled more than a hundred million names this past year for its clients.

"Our Creative Services Division has developed complementary mail marketing programs designed primarily to utilize our lists of several million policyowners and former policyholders. Those programs could be expanded beyond our present markets.

"The Creative Services Division also produces the 'Family Album' quarterlies, calendar and birthday booklets—all of which are sent to our policyowners during the year. Another area of potential growth for National Consumer Marketing is in the generation of sales leads for regional and national organizations for such products and services as mutual funds, real estate and insurance.

"In addition, and in conjunction with a major distributor of pharmaceuticals, we are developing a direct marketing program of prescriptions by mail at substantial savings to the consumer. This activity recognizes and responds to the needs of the senior citizen, where both low price and convenience of shopping by mail are not only important but in some cases imperative.

"It is our belief that the services provided by these operating units, in conjunction with the services of other member companies of the National Liberty Group, and augmented by the financial capabilities of our parent corporation, are unique in the direct marketing field, which recently has been growing rapidly and expanding beyond its traditional bounds.

"Perhaps most important and gratifying is the fact that although we are now just two years old, we have been able to lay exceptionally good groundwork for continued and expanded growth in both revenues and earnings for the years ahead," Cavanagh concludes.

Preparing inquiry kits for TV stations





During a moment of reflection on the drive back to National Liberty's home office where you will pick up your car, you recall some of the other facts you've learned today.

... More than \$80 million in revenues in twelve years.

... More than 1,600,000 policyowners.

... Magnificent new building with ample room for expansion.

... More than 1,000 vibrant and enthusiastic employees.

... A youthful management team of proven accomplishment and competence.

... Thorough, extensive, and scientifically developed marketing plans.

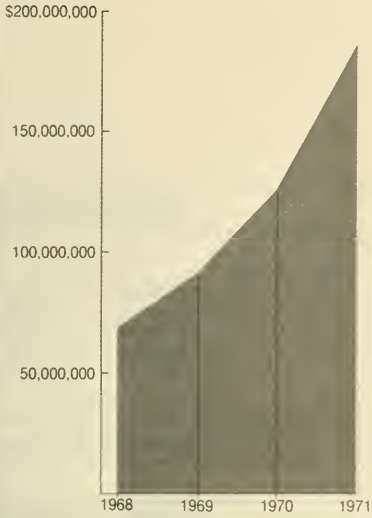
... Recognition and support by the nation's financial community.

... An estimated corporate market value of over \$400 million.

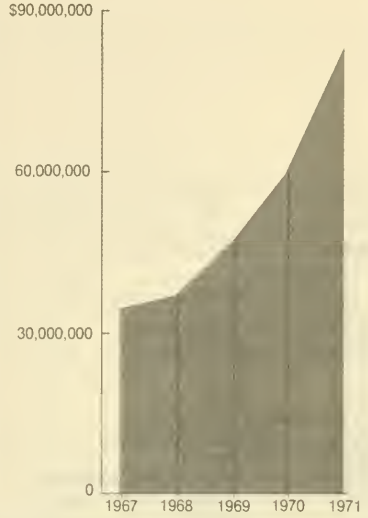
As you approach the building, silhouetted against the brilliant hues of the late afternoon sky and dramatically mirrored in the adjacent pond, you can understand the feeling of great pride shown by so many of the people met during today's tour.

And, as a shareholder, you can take pride in the people, potential and profits of National Liberty Corporation, *your* Corporation.

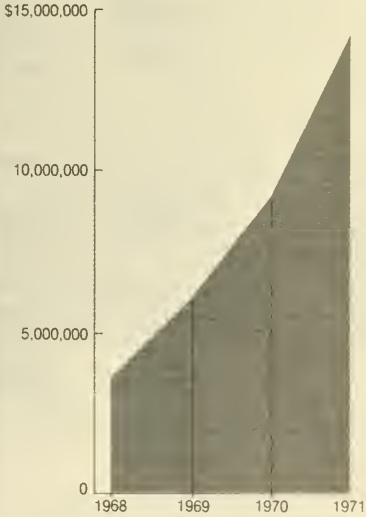
**National Liberty Corporation
Total Assets**



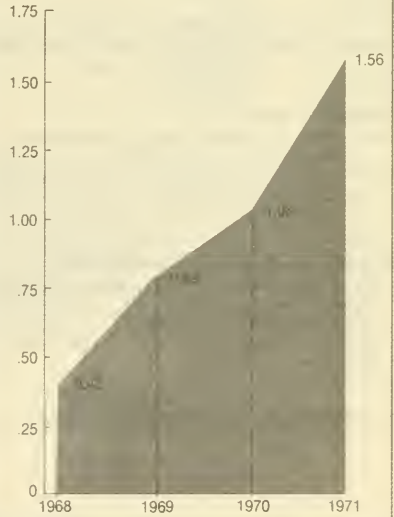
**National Liberty Corporation
Five Year Revenue Summary**



**National Liberty Corporation
Net Income ***



**National Liberty Corporation
Net Income Per Share ***



* Income before investment gains or losses and extraordinary items.

Consolidated Statement of Income For The Years 1971 and 1970

National Liberty Corporation and Subsidiary Companies

	Year Ended December 31	
	1971	1970
Revenues:		
Premium income:		
Accident and health	\$68,204,068	\$46,791,736
Life	8,763,212	7,159,461
Commission and service income	4,175,670	2,889,478
Investment and other income	3,669,909	2,694,355
	<u>84,812,859</u>	<u>59,535,030</u>
Costs and expenses:		
Accident and health and other benefits	32,958,982	20,388,136
Increase in policy reserves	6,781,861	6,902,022
Policy acquisition costs and operating expenses	61,550,622	41,233,961
Increase in deferred policy acquisition costs	(36,228,181)	(21,710,128)
	<u>65,063,284</u>	<u>46,813,991</u>
Income before income taxes, etc.	<u>19,749,575</u>	<u>12,721,039</u>
Provision for income taxes:		
Deferred	5,550,786	3,517,491
State	47,748	34,230
	<u>5,598,534</u>	<u>3,551,721</u>
Income before investment losses and extraordinary items	14,151,041	9,169,318
Investment losses, net of related deferred income taxes	(13,134)	(682,948)
Income before extraordinary items	<u>14,137,907</u>	<u>8,486,370</u>
Extraordinary items:		
Gain on sale of portfolio of insurance, net of related deferred income taxes of \$1,082,958	—	3,353,726
Charge principally resulting from writedown of goodwill by a consolidated subsidiary	(292,714)	—
Net income	<u>\$13,845,193</u>	<u>\$11,840,096</u>
Net income (loss) per share of common stock:		
Income before investment losses and extraordinary items	\$1.56	\$1.04
Investment losses	—	(.08)
Income before extraordinary items	<u>1.56</u>	<u>.96</u>
Extraordinary items	<u>(.03)</u>	<u>.38</u>
Net income	<u>\$1.53</u>	<u>\$1.34</u>

See accompanying notes to consolidated financial statements

Consolidated Balance Sheet December 31, 1971 and 1970

National Liberty Corporation and Subsidiary Companies

ASSETS	1971	1970
Cash	<u>\$ 5,053,904</u>	<u>\$ 5,164,604</u>
Investments in securities:		
Life insurance subsidiaries:		
Bonds	52,077,153	31,877,402
Preferred stocks	585,719	631,132
Common stocks	20,625	451,802
	<u>52,683,497</u>	<u>32,960,336</u>
Other, at cost:		
Bonds and commercial paper	1,046,236	440,294
Common stocks (quoted market value \$206,515 and \$53,632, respectively)	255,861	96,290
Common stocks (restricted as to negotiability)	<u>217,198</u>	<u>293,775</u>
	<u>54,202,792</u>	<u>33,790,695</u>
Mortgage loans and other receivables	5,777,975	4,381,145
Premiums due and deferred	<u>3,388,147</u>	<u>2,717,174</u>
Property and equipment, at cost:		
Land	1,523,405	872,564
Home office and other buildings	9,250,519	7,634,546
Equipment	2,287,306	1,729,750
	<u>13,061,230</u>	<u>10,236,860</u>
Less accumulated depreciation	<u>777,007</u>	<u>533,523</u>
	<u>12,284,223</u>	<u>9,703,337</u>
Deferred policy acquisition costs	99,493,528	63,265,347
Other assets	10,007,136	5,068,509
	<u>\$190,207,705</u>	<u>\$124,090,811</u>

See accompanying notes to consolidated financial statements

**REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS
National Liberty Corporation, Liberty Park, Frazer, Pennsylvania**

We have examined the consolidated balance sheet of National Liberty Corporation and subsidiary companies as of December 31, 1971 and 1970 and the related consolidated statements of income, retained earnings and changes in financial position for the years then ended which have been restated as to 1970 with respect to the poolings of interests as described in Note 1. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We did not examine the financial statements of National Home Life Assurance Company (a consolidated subsidiary) for the year ended December 31, 1970 whose total assets and revenues constituted 40% and 53% respectively of consolidated amounts for that year, such statements were examined by other auditors whose report thereon has been furnished to us. Our opinion expressed herein, insofar as it relates to the amounts included for said company, for the year ended December 31, 1970, is based solely upon such report.

In our opinion, based on our examination and the report for the year ended December 31, 1970 of other auditors, the aforementioned financial statements (pages 19 to 26 inclusive) present fairly the consolidated financial position of National Liberty Corporation and subsidiary companies at December 31, 1971 and 1970 and the consolidated results of their operations and their consolidated changes in financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Philadelphia, Pennsylvania
March 15, 1972

Lybrand, Ross Bros. & Montgomery

LIABILITIES	1971	1970
Policy reserves and unearned premiums	\$ 49,757,311	\$ 37,332,584
Claims and benefits payable	8,122,975	5,798,114
Notes payable and long-term debt, including current maturities of \$8,129,871 and \$5,522,519, respectively	16,211,709	8,135,024
Accounts payable	6,723,139	3,396,254
Accrued expenses (principally solicitation expenses and premium taxes)	9,110,490	5,544,669
Income taxes:		
Current	36,422	22,706
Deferred	24,056,464	18,678,448
Minority interest in subsidiaries	1,125,759	1,035,924
	<u>115,144,269</u>	<u>79,943,723</u>

SHAREHOLDERS' EQUITY

Preferred stock, \$1 par value; authorized 500,000 shares; none issued	—	—
Common stock, \$1 par value; authorized, 1971—12,500,000, shares, 1970—7,500,000 shares; issued and outstanding, 1971—9,310,061 shares, 1970—6,606,296 shares	9,310,061	6,606,296
Capital in excess of par value	19,917,005	5,549,615
Retained earnings	45,836,370	31,991,177
	<u>75,063,436</u>	<u>44,147,088</u>
	<u>\$190,207,705</u>	<u>\$124,090,811</u>

CONSOLIDATED STATEMENT OF RETAINED EARNINGS FOR THE YEARS 1971 AND 1970

	1971	1970
Balance, January 1, as restated (\$503,111 reduction in 1970) for companies acquired on pooling of interests basis—see Note 1	\$ 31,991,177	\$ 20,151,081
Net income	13,845,193	11,840,096
Balance, December 31	<u>\$ 45,836,370</u>	<u>\$ 31,991,177</u>

See accompanying notes to consolidated financial statements

Consolidated Statement of Changes in Financial Position For the Years 1971 and 1970

National Liberty Corporation and Subsidiary Companies

	Year Ended December 31	
	1971	1970
Source of Funds:		
Income before extraordinary items (1971 items not requiring outlay of funds)	\$ 14,137,907	\$ 8,486,370
Increase (decrease) due to changes in:		
Premiums due and deferred	(670,973)	(611,864)
Deferred policy acquisition costs	(36,228,181)	(21,710,128)
Other assets	(2,176,951)	(1,422,281)
Policy reserves and unearned premiums	12,424,727	8,106,944
Policy claim liabilities	2,324,861	59,453
Accounts payable and other liabilities	2,765,397	1,992,299
Deferred income taxes	5,550,786	3,517,491
Other adjustments:		
Investment losses	13,134	762,639
Amortization of bond premium and discount	(32,655)	(33,508)
Depreciation	379,305	194,815
Funds used in operations before extraordinary gain	(1,512,643)	(657,770)
Extraordinary gain plus deferred taxes and other deductions of \$681,935 not requiring outlay of funds	—	4,035,661
Funds provided (used) in operations	(1,512,643)	3,377,891
Increase in premiums received in advance	239,817	2,983
New notes payable and long-term debt	52,180,551	18,228,686
Proceeds from sale of investments	118,123,077	93,617,456
Proceeds from sale of common stock, net of expenses of \$239,957	16,960,043	—
Other transactions, net	132,047	267,997
	<u>186,122,892</u>	<u>115,495,013</u>
Application of Funds:		
Increase in mortgage and policy loans	783,989	415,385
Purchase of investments	138,385,546	96,358,514
Plant additions	2,960,191	5,572,846
Repayment of notes payable and long-term debt	44,103,866	12,264,169
	<u>186,233,592</u>	<u>114,610,914</u>
Net increase (decrease) in cash	(110,700)	884,099
Cash balances:		
January 1	5,164,604	4,280,505
December 31	<u>\$ 5,053,904</u>	<u>\$ 5,164,604</u>

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

National Liberty Corporation and Subsidiary Companies

1. Basis of Statement Presentation:

The consolidated financial statements include the accounts of National Liberty Corporation and all its subsidiary companies. The accounts of life insurance subsidiaries have been adjusted in accordance with the principles contained in the exposure draft dated December, 1970, prepared by the Committee on Insurance Accounting and Auditing of the American Institute of Certified Public Accountants entitled "Audits of Life Insurance Companies" (see Note 2). Such exposure draft has not yet been adopted.

In December, 1971, (1) the Company acquired all of the outstanding shares of Financial International Consultants Corporation in exchange for 15,033 shares of its common stock and (2) a majority-owned subsidiary acquired all the outstanding shares of a non-affiliated company in exchange for 880,086 shares of its common stock. Both transactions were treated as poolings of interests and accordingly the accompanying consolidated financial statements include the operations of both companies prior to their acquisition.

The revenues, extraordinary items, and net income (loss) of National Liberty Corporation (prior to poolings) and the aforementioned pooled companies for the years 1971 and 1970 are as follows:

	Revenues	Extraordinary Charges (Credits)	Net Income
1971:			
National Liberty Corporation ...	\$82,415,636	\$ (351,782)	\$13,676,995
Pooled Companies ...	2,397,223	59,068	168,198
	<u>\$84,812,859</u>	<u>\$ (292,714)</u>	<u>\$13,845,193</u>
1970:			
National Liberty Corporation ...	\$57,672,895	\$3,353,726	\$12,109,059
Pooled Companies ...	1,862,135	—	(268,963)
	<u>\$59,535,030</u>	<u>\$3,353,726</u>	<u>\$11,840,096</u>

2. Statutory Accounting Practices:

The financial statements of the Company's life insurance subsidiaries filed with the insurance departments of their respective states of domicile are prepared in accordance

with the practices prescribed or permitted by such regulatory authorities which differ in certain respects from the principles employed in preparing the accompanying consolidated financial statements. The principal differences are (1) financial statements of the companies, which are presented on a separate company basis for statutory purposes, have been consolidated, (2) policy acquisition costs, which are charged against operations as incurred for statutory purposes, have been deferred and amortized over the periods benefited, (3) policy reserves, which are stated principally on modified reserve methods for statutory purposes, have been restated on a net level basis using revised assumptions, (4) certain assets designated as "non-admitted", which are excluded from the balance sheet for statutory purposes, have been restored (the term "non-admitted" assets means assets other than assets which are permitted to be reported to regulatory authorities), (5) the contingency reserve, "Mandatory Securities Valuation Reserve", which is required to be shown as a liability for statutory purposes, has been restored to surplus, (6) investment gains and losses, which are reflected in surplus for statutory purposes, have been reflected in income, (7) deferred taxes, which are not recognized for statutory purposes, have been provided and (8) extraordinary items, required to be shown in surplus for statutory purposes, have been reflected in income.

3. Bonds and Stocks:

Bonds and stocks held by insurance subsidiaries are carried at values prescribed by the National Association of Insurance Commissioners. In general, bonds are stated at amortized cost, preferred stocks at cost and common stocks at market value. At December 31, 1971, the aggregate cost or amortized cost of such investments amounted to \$52,844,957 as compared with a related market value of \$50,595,829. Market value consists of quoted market value except for certain issues (principally private placements) in the aggregate amount of \$8,063,528 which are valued at cost or amortized cost and for which quoted market values are not available.

4. Policy Acquisition Costs:

Under the principles contained in the AICPA exposure draft (see Notes 1 and 2) the Company amortizes policy ac-

Notes to Consolidated Financial Statements (Continued)

National Liberty Corporation and Subsidiary Companies

acquisition costs principally over a twenty-year period using a declining balance method. Such method is based on the Company's actual and projected persistency experience.

5. Policy Reserves:

The aggregate reserves for all policies on a statutory basis, at December 31, 1971, were determined on the following standards:

	Amount
Accident and Health policies:	
Unearned premium based on monthly pro rata factors	\$16,701,382
Additional reserves for guaranteed renewable policies, two-year preliminary term method (1956 hospital and surgical tablets—1941 C.S.O., 2½%)	10,720,440
Present value of amounts not yet due on claims	975,121
Total	<u>28,396,943</u>
Life Policies:	
A.E. 3½% Illinois Std.	462,616
C.S.O. Commissioners Reserve Valuation Method—1941-1958, 2½% to 3½%	8,171,454
C.S.O. net level 1941-1958, 2½% to 3½%	2,058,797
Others	1,173,028
Total	<u>11,665,895</u>
Total reserves statutory basis	40,262,838
Adjustment to net level basis using revised assumptions (see Notes 1 and 2)	9,449,141
	<u>49,711,979</u>
Supplementary contracts without life contingencies and dividend accumulations	45,332
Policy reserves and unearned premiums as shown in accompanying balance sheet	<u>\$49,757,311</u>

6. Notes Payable and Long-Term Debt:

At December 31, 1971, notes payable and long-term debt consisted of the following:

5¼% Short-term bank notes payable . . . \$ 7,750,000

5¾% Convertible subordinated debentures	2,000,000
8½% Mortgage loan on home office building	4,484,840
Sundry other long-term debt	1,976,869
	<u>\$16,211,709</u>

The 5¾% convertible subordinated debentures will be subordinated to any allowable funded debt which the Company may incur in the future. The debentures are convertible into common stock at \$21.60 per share (subject to anti-dilution provisions), and 92,592 shares of common stock have been reserved for this purpose. Terms of the debentures provide, among other things, for (1) repayment of \$100,000 annually commencing on December 15, 1979, and each year thereafter to December 15, 1983, with the balance of \$1,500,000 due December 15, 1984, (2) redemption in whole or in part, at the option of the Company, at 105¼% of the principal amount to December 15, 1972, and at lesser amounts to December 15, 1983, and without premium thereafter, and (3) certain restrictions on the payment of cash dividends, repurchase of capital stock and the amount of funded debt that the Company may incur. At December 31, 1971, approximately \$15,500,000 of consolidated retained earnings are free of restriction with respect to the payment of cash dividends on common stock.

The mortgage loan is payable in monthly installments of \$35,625, including interest, and the principal balance of approximately \$3,145,000 is due September 1, 1986.

7. Federal and Deferred Income Taxes:

For income tax purposes, the Company charges policy acquisition costs to income as incurred, while for financial purposes such costs are deferred and amortized over the periods benefited. Deferred income taxes relate principally to the difference in reporting these costs for financial and tax purposes.

At December 31, 1971, net operating loss carry-forwards of approximately \$40,146,000 are available to offset future taxable income, if any, and expire as follows:

1972	\$ 1,546,000
1973	1,935,000
1974	2,070,000
1975	12,050,000
1976	22,545,000
	<u>\$40,146,000</u>

Notes to Consolidated Financial Statements (Continued)

National Liberty Corporation and Subsidiary Companies

The Company and its 80% or more owned subsidiaries, except life insurance subsidiaries, file a consolidated federal income tax return. The provisions for income taxes of the consolidated life insurance subsidiaries are not proportional to their pre-tax financial statement income due to various exclusions and special deductions, etc., afforded such companies under the Internal Revenue Code.

At December 31, 1971, accumulated earnings of the life insurance subsidiaries for federal income tax purposes includes approximately \$3,420,000 of "Policyholders' Surplus" as defined under the Life Insurance Company Tax Act of 1959. Under provisions of the Act, "Policyholders' Surplus" has not been currently taxed and income taxes, computed at current rates and amounting to \$1,640,000, would become payable if this surplus were distributed to National Liberty Corporation. There is no present intention to make such distributions. At December 31, 1971, "Policyholders' Surplus" recomputed under generally accepted accounting principles amounted to \$26,400,000 and the related income taxes that would become payable upon its distribution amounted to \$12,670,000 of which \$3,950,000 and \$3,290,000 would apply to the years 1971 and 1970, respectively.

8. Common Stock and Capital in Excess of Par Value:

The changes in the common stock and capital in excess of par value accounts for the years 1970 and 1971, are as follows:

	Common Stock		Capital in
	Shares	Amount	Excess of Par Value
Balances, January 1, 1970 ...	5,275,029	\$5,275,029	\$ 5,943,514
Transfer in connection with five-for-four stock distribution ..	1,318,792	1,318,792	(1,318,792)
Increase resulting from an acquisition of a company by issuance of common stock of a majority- owned subsidiary ..	—	—	423,483
Issuance of stock upon exercise of qualified stock options	1,200	1,200	14,600

Balances, December 31, 1970 (Before companies accounted for on poolings of interests.)	6,595,021	6,595,021	5,062,805
Transfer in connection with four-for-three stock distribution ..	2,198,340	2,198,340	(2,198,340)
Sale of stock, net of expenses of \$239,957	500,000	500,000	16,460,043
Issuance of stock upon exercise of qualified stock options	1,667	1,667	16,237
Issuance of stock in exchange for capital stock of a company accounted for on a pooling of interests basis	15,033	15,033	450,728
Increase resulting from an acquisition of a company by issuance of common stock of a majority- owned company ...	—	—	125,532
Balances, December 31, 1971 (see Note 13)	9,310,061	\$9,310,061	\$19,917,005

9. Stock Options and Stock Purchase Plan:

At December 31, 1971, 148,933 shares of the Company's common stock were reserved for issuance under the Company's qualified stock option plan. Options are granted to key employees to purchase common stock at not less than current market prices on the date of grant. Options are exercisable at various annual rates from date of grant and expire five years thereafter.

During 1971, options to purchase 9,150 shares were granted, options for 1,667 shares were exercised and options for 3,149 shares were terminated.

At December 31, 1971, options to purchase 54,016 shares (of which 22,266 shares were exercisable) were outstanding at prices ranging from \$7.75 to \$41.25 per

Notes to Consolidated Financial Statements (Continued)

National Liberty Corporation and Subsidiary Companies

share for an aggregate of \$996,037, options for 10,767 shares are exercisable in the future contingent upon certain performance standards and 94,917 shares were reserved for options which have not yet been granted. The above amounts have been adjusted for stock distributions through December 31, 1971.

The Company's majority-owned subsidiary, National Information Systems Corporation, has a similar qualified stock option plan under which, at December 31, 1971, 113,671 shares have been granted and 39,900 shares are reserved for options which have not yet been granted.

Under the Company's Stock Purchase Plan, certain eligible employees may elect to have a percentage of their compensation withheld through payroll deductions and, depending upon earnings, the consolidated companies match from 25% to 100% of each participant's contributions. All funds in the Plan are used to purchase the Company's common stock in the open market. Charges to income with respect to the Plan aggregated \$118,761 and \$66,891 in 1971 and 1970, respectively.

10. Profit-Sharing Plan and Depreciation:

Under the Company's "Employees Profit-Sharing Plan", the Company and qualified subsidiaries contribute a portion of their consolidated income before income taxes as determined by the Companies' Boards of Directors, not to exceed 15% of the aggregate compensation of plan members. Contributions charged to income under the plan amounted to \$144,531 in 1971 and \$131,249 in 1970. The Company's life insurance subsidiary (National Home Life Assurance Company) had a pension plan which resulted in pension expense of \$12,000 in 1970, including amortization of prior service cost over a fifteen-year period. This plan was terminated on January 1, 1971, and integrated into the aforementioned "Employee Profit-Sharing Plan."

Depreciation is computed under the straight-line method and depreciation expense amounted to \$379,305 in 1971 and \$194,815 in 1970.

11. Leases:

At December 31, 1971, the Company and its subsidiaries leased premises and data processing equipment for various terms at aggregate annual rentals of approximately \$1,680,000.

12. Net Income Per Share of Common Stock:

Net income per share of common stock is based on the average number of shares outstanding during 1971 and 1970 adjusted for (1) common stock issued in connection with a 1971 acquisition accounted for on a pooling of interests basis, (2) stock distributions through December 31, 1971, (see Note 13) and (3) conversion of the 5¾% convertible debentures at date of issue and the exercise of outstanding stock options, which are common stock equivalents.

13. Subsequent Events:

On February 1, 1972, the Board of Directors of the Company, subject to Shareholders' approval at the annual meeting in May, 1972, adopted resolutions providing for (1) an increase in the authorized common stock from 12,500,000 shares to 16,500,000 shares and (2) a stock distribution by the issuance of one share of common stock for each two shares of common stock held of record on May 15, 1972. Had these shares been issued at December 31, 1971, the net income (loss) per share of common stock presented on the accompanying consolidated statement of income would be as follows:

	1971	1970
Income before investment losses		
and extraordinary items	\$1.04	\$.69
Investment losses	—	(.05)
Income before extraordinary items	1.04	.64
Extraordinary items	(.02)	.25
Net income	<u>\$1.02</u>	<u>\$.89</u>

The Company has entered into negotiations with Old Equity Financial Corporation, an insurance holding company located in Evanston, Illinois, relating to a proposed offer by the Company to exchange its shares of common stock for the common stock of Old Equity Financial Corporation. Although no binding agreements have been made, the exchange ratios being negotiated would involve the exchange of four common shares of Old Equity Financial Corporation for one common share of the Company. The Company can give no assurance that any transaction will in fact materialize. Approval for this transaction, if consummated, must be obtained from various insurance regulatory bodies.

GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP) AT NATIONAL LIBERTY

As of December 31, 1970, National Liberty revised its method of reporting to conform with the accounting principles contained in *Audit Guide For Life Insurance Companies*, which was released as an exposure draft in December 1970 by the American Institute of Certified Public Accountants.

This new method of reporting recognizes that insurance is a business of long-term contracts, and that costs must be matched with revenues for insurance company reporting, which is the generally accepted accounting principle of reporting for all industries. The prior method of reporting, the so-called "statutory basis," was in accordance with the accounting principles promulgated by the National Association of Insurance Commissioners, which is basically a test of solvency, essentially assuming that the company would be liquidated as of the balance sheet date. Because insurance is a business of public trust, we feel this "statutory" method is a mandatory way of reporting our financial condition to the insurance regulators who have the responsibility of seeing that the policyowners are adequately protected. However, the shareholders of the Corporation have a right to know the financial results on the same "going-concern basis" of reporting that is used by other industries.

In applying generally accepted accounting principles at National Liberty, it is important to note that, in direct response business, the entire investment in acquiring new business is made before any income is received. Also, policies are designed to return benefits to the policyowners of 55-65% of premiums collected. This ratio is achieved by paying about 25% claim cost in the first policy year, 35% in the second year, and a ratio that increases about 5% a year thereafter.

Hence, to match cost with revenue, it is necessary first of all to determine the expected revenue to be received from the sale of the new block of business. The investment in acquiring the block of business is then capitalized. It is amortized over the expected revenue cycle. The Company must also establish an immediate liability for the rising future claim costs. In determining the expected revenue to be received, the persistency

assumption is determined by first using the same assumption that was used in pricing the policy, and then modifying that assumption to take into account actual experience.

As of December 31, 1970, studies enabled us to develop the history of persistency for 5 years. Therefore, this data was used in the calculation while, after the fifth year, a standard actuarial table which approximated the persistency assumption used in establishing premium rates to determine expected revenue was used. The expected revenue curve was arbitrarily cut off after 20 years. By this calculation, it is expected that approximately 12% of revenue will be received in the first policy year, and 50% in the first seven years. In 1971, a new computer program enabled us to obtain persistency data since the inception of the company. This data indicated that persistency was at least as good as had been projected for the sixth and subsequent years. The data indicated that policies in the seventh year were terminating at the rate of 9% per year, and in the eighth and subsequent years the lapse was 8%. This was higher than was projected in determining the revenue curve at December 31, 1970. The calculation for amortization in 1971 used the lower expected revenue curve. This resulted in about 13% of revenue coming in the first year and 50% in slightly over five years.

This expected revenue curve is used to determine the amortization of acquisition costs. The additional liability for policy reserves is established by using standard actuarial tables, while the liability for deferred federal income taxes is calculated in the same manner as is used by other industries.

For National Liberty, the above items are the primary adjustments required for converting to generally accepted accounting principles. It is our opinion that this method fairly matches cost with revenue on a conservative basis, and we are delighted that the independent outside auditors of the Corporation have been able to express their opinion on the numbers produced by this method elsewhere in this report.

National Liberty Corporation

*Founder, President and Chief
Executive Officer*

A. ARTHUR S. DE MOSS

*Chairman of the Board and
Chief Operating Officer*

B. ROBERT E. SLATER

Senior Vice President

C. RICHARD WOIKE

*Vice Presidents
GERALD F. BEAVAN
(Public Relations)**

D. JAMES D. ELLIOTT
(Corporate Services)

E. ANDREW L. HEISKELL
(Investments)

F. WILLIAM A. PATTY
(General Counsel)

G. ROBERT O. SAFFORD
(Executive V.P.—Sales)

*Vice President—Finance, and
Treasurer*

H. W. BENJAMIN WEAVER

*Secretary and Associate
Counsel*

J. DANIEL W. B. FLINT

**Appointed Feb. 1972, no photo available*

Directory of Officers



De Moss Associates, Inc.*Chairman of the Board*

EMERSON FOOTE

President

WILLIAM H. SHIPLEY

Senior Vice Presidents

KENNETH E. CLOLERY

ROLF F. DEHMEL

HUGH P. WHITTED

GEORGE R. ZILLING

Vice Presidents

GEORGE DE MOSS

RICHARD H. GEIST

THOMAS D. JEWELL

J. BARRY LOVE

THOMAS E. McCABE

ROBERT T. RAKICH

DONALD P. WILLIAMSON

Treasurer

W. BENJAMIN WEAVER

Secretary

J. BARRY LOVE

National Liberty Life Insurance Company*Chairman of the Board*

ROBERT E. SLATER

President

JOHN W. KELLER

Vice Presidents

GEORGE DE MOSS

ANDREW L. HEISKELL

(Investments)

RICHARD W. OLIVER

(Operations)

WILLIAM A. PATTY

HARRY B. VERSTANDIG

*(Management Services Division)**Vice President and Treasurer*

LARRY A. WAGNER

Secretary and General Counsel

DANIEL W. B. FLINT

National Home Life Assurance Company*Chairman of the Board*

ROBERT E. SLATER

President

T. ROBERT WILCOX

Executive Vice President

FRANK W. ANDERSON

Vice Presidents

GEORGE DE MOSS

JOHN W. KELLER

(Administration)

ANDREW L. HEISKELL

JEROME H. GRADY

(Regional)

SANFORD W. SCOTT, JR., FSA

(Actuary)

JOHN A. VORACEK

Vice President and Treasurer

WATER C. BARRY

Vice President and Secretary

WILLIAM C. KEANE

National Home Assurance Company of New York*Chairman of the Board*

ROBERT E. SLATER

President

ARTHUR S. DE MOSS

Vice Presidents

GEORGE DE MOSS

ANDREW L. HEISKELL

(Investments)

JOHN W. KELLER

T. ROBERT WILCOX

Vice President and Treasurer

W. BENJAMIN WEAVER

Secretary

DONALD D. KENNEDY, JR.

National Information Systems Corporation*President*

CARL G. SEMPIER

Chairman, Executive Committee

JOSEPH A. GATTUSO

Executive Vice President

GERALD R. CICONI

Senior Vice President

WILLIAM K. KLEMENS

Vice Presidents

JOHN F. ALFIERI

CHARLES S. COSTANZO

JAMES J. DOUGHERTY

EDWARD G. HAGGERTY

KEITH D. QUACKENBUSH

WILLIAM J. ROCHE

STEPHEN E. SARGENT

JOHN G. WALTERICK

Secretary

MICHAEL J. HAGGERTY

Treasurer

R. DONALD PETERSON

National Consumer Marketing Corporation*President*

CHARLES M. CAVANAGH

Senior Vice President

ROBERT J. MARSH

Vice Presidents

WARREN L. LEVY

RICHARD M. MILLER

CHARLES J. WEIGERT

Treasurer

W. BENJAMIN WEAVER

Secretary

FRANK H. MINNER, JR.



National Liberty Corporation

- A. FRANK CARLSON**
Former U.S. Senator—Kansas
- B. JOSEPH F. DECOSIMO**
C.P.A., Joseph Decosimo & Company, Chattanooga, Tennessee
- C. WALLACE A. ERICKSON**
President, Wallace Erickson and Company, Chicago, Illinois
- D. EMERSON FOOTE**
Chairman of the Board, De Moss Associates, Inc. Advertising Consultant Former Chairman—Foote, Cone & Belding
- E. DAVID H. JAQUITH**
Chairman of the Board, Vega Industries, Inc., Syracuse, N.Y.
- F. ART LINKLETTER**
Chairman of the Board, Linkletter Enterprises
- G. HARVEY SCHARFMAN**
President, Cotton Club Frocks, Inc., New York, N.Y. President, Hanover Manufacturing Corporation, Amsterdam, N.Y.
- H. CARL SCHUMACHER**
President, Hickey-Mitchell Co., St. Louis, Mo.
- W. MARVIN WATSON**
President, Occidental International Corporation Former Postmaster General of the United States
No photograph available

- ARTHUR S. DE MOSS**
Founder, President and Chief Executive Officer, National Liberty Corporation
- ROBERT E. SLATER**
Chairman of the Board and Chief Operating Officer, National Liberty Corporation
- CHARLES M. CAVANAGH**
President, National Consumer Marketing Corporation
- JOHN W. KELLER**
President, National Liberty Life Insurance Company
- WILLIAM A. PATTY**
Vice President and Counsel, National Liberty Corporation
- CARL G. SEMPIER**
President, National Information Systems Corporation
- WILLIAM H. SHIPLEY**
President, De Moss Associates, Inc.
- T. ROBERT WILCOX**
President, National Home Life Assurance Company
- RICHARD WOIKE**
Senior Vice President, National Liberty Corporation

Directors



Directory

COUNSEL:
Dechert, Price & Rhoades,
Philadelphia, Pa.

AUDITORS:
Lybrand, Ross Bros. &
Montgomery

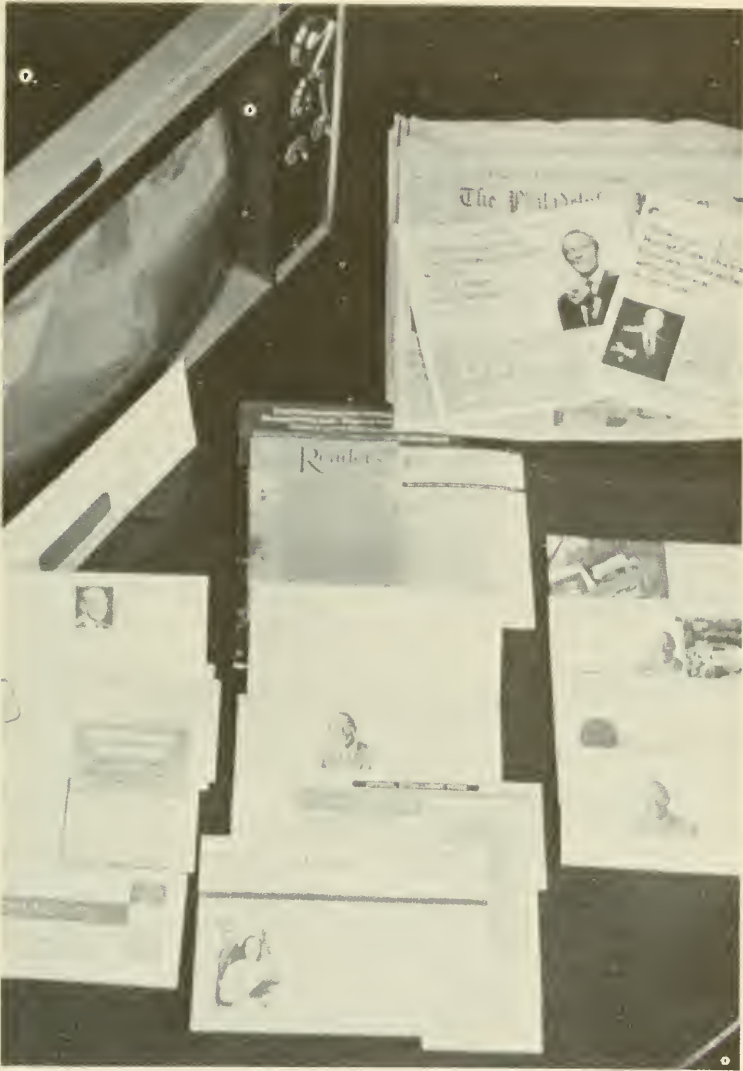
REGISTER & TRANSFER
AGENT:
Girard Trust Bank

Annual Meeting: May 23rd,
1972, at 3:00 p.m. at Corporate
Headquarters

Corporate Headquarters:
Liberty Park
Frazer, Pennsylvania 19355

Mailing Address:
Valley Forge, Pennsylvania 19481





Above: A random sampling of media—television, newspapers and magazines— employed in our marketing activities, with examples of free fall inserts and direct mail pieces. In 1971, between newspaper impressions and direct mail pieces, over 760 million potential policyowners were reached.

Supplemental Health Insurance and the Public Interest

As the broad issue of consumerism assumes even greater importance, National Liberty Corporation continues to take the lead in aggressive efforts to help what might be termed a "neglected minority," even though, as the following facts reveal, this is a "minority" of substantial proportions.

It is reliably reported that 80 percent of the population under 65 today has some form of private health insurance coverage. Additionally, Medicare provides some protection for 95 percent of the elderly. Despite these seemingly encouraging statistics, the fact is that most American families are insufficiently protected against serious illness and accident.

For example, of the \$67 billion spent on health care in 1970, a staggering \$25 billion (or 40 percent) had to be paid by individuals out of income, savings—or in some cases, by going into debt. The percentages of health care expense not covered by insurance or paid by the government are indicated in the following summary:

Hospital Care	19%
Surgical Services	21%
In-hospital Visits	30%
X-ray and Lab	35%
Office & Home Visits	57%
Dental Care	95%
Prescribed Drugs	52%
Nursing Home Care	87%
Private Duty Nursing	52%
Visiting Nurse Service	47%

From: *Basic Facts on the Health Industry*, prepared by the staff of Health Committee Ways and Means of the United States House of Representatives. For persons under 65 (1961, Page 96).

The magnitude of this problem—and it is one which is likely to continue—is seen in the graph following, which indicates that the cost of medical and hospital care in America has risen more rapidly than any other major sector of the economy.

Growth in health expenditures, 1950-1970



Growth in medical prices, 1960-1970



Reprinted with permission, Department of Health and Education and Welfare White Paper, entitled: *Towards a Comprehensive Health Policy for the 1970's* (Pages 21 and 22).

The limited role of traditional forms of health insurance protection in meeting health care costs may be attributed to four key factors:

1. The fact that many individuals, because of age or physical impairment cannot qualify for health insurance.
2. The gaps, limitations and exclusions in coverage afforded by traditional hospital expense reimbursement insurance.
3. The high cost of such coverage.
4. The lack of adequate marketing through agency methods.

Supplemental hospital insurance, marketed through the mails and offering fixed

cash benefits for each day that the insured is confined to the hospital, has been available for many years. It has been during the last decade, however, that this form of insurance has developed into a true mass-marketed product, and that its volume has become substantial. The rising medical costs, and the tightened underwriting standards of the traditional hospitalization programs have hastened this development.

Today over 50 percent of all new issues of individual hospital policies are of the mass-marketed, supplemental indemnity type. And while there are some 800 companies offering supplemental hospital indemnity coverage, 90 percent of the business is written by only 12 companies, and of these the National Liberty Group of companies is the acknowledged industry leader.

This insurance is made available to those who cannot be economically served by conventional face-to-face marketing techniques. Anyone who has a mailbox, or access to a radio, newspaper or television, also has access to supplemental hospital insurance. Thus the "neglected minority" is being served by National Liberty.

We have served the health insurance market for more than a decade. Protection has been made available to multiplied thousands of families not customarily reached by conventional agency methods because the premiums are so low. And even though the benefits, being supplemental in nature, do not provide complete coverage to many policyowners they have meant the difference between mere misfortune and financial disaster.



Mr. SHARP. Are there any other States, besides California and Oklahoma, that have followed Washington State in ordering your company, as well as the Bankers Life & Casualty, to stop circulating ads with Mr. Linkletter and Paul Harvey, on the grounds that neither are licensed insurance agents in those States?

What are you doing now in trying to get Mr. Linkletter licensed as an agent in this regard?

Mr. SLATER. We are experiencing problems in this connection, and I might say that in those areas where we have experienced the problem, that the advertising was all cleared prior to the publication.

We are now going through, in some States—they are saying that Mr. Linkletter needs to be licensed. The fact of the matter is that if a man is a director of a company, or an officer of a company, he can sell insurance in that company without a license, provided he doesn't get a commission.

Mr. SHARP. Is that what the——

Mr. SLATER. Now, California states specifically that Mr. Linkletter does not have to be licensed and should not be licensed. Now, this is creating problems. For instance, Oklahoma says, "Well, he has to be." You cannot be licensed in Oklahoma unless you are licensed in your own State, and he happens to be a resident of California.

I think that we have had our ads reapproved in California and we expect that most of these difficulties that we are having throughout the country—and I think it is about 14 States—will be resolved in 30 days.

Mr. SHARP. Would you supply lists of these 14 States with a brief description of the difficulties that you are having?

Mr. SLATER. We will be glad to.

Mr. CHUMBRIS. Will counsel yield. While on the subject of States, the States of Oklahoma, California, and the State of Washington were mentioned. This has to do with your advertising, is that correct?

Mr. SLATER. I am sorry, sir?

Mr. CHUMBRIS. This has to do with the advertising?

Mr. SLATER. It is primarily with the endorsement of Art Linkletter.

Mr. CHUMBRIS. It has nothing to do with your selling policies in those States?

Mr. SLATER. No, sir. It has primarily to do with—Ohio is another State, I might say—and it has to do primarily with the endorsement by Mr. Linkletter.

Now, it is a question of whether he is endorsing or whether he is selling. Some States are maintaining that he is, in fact, selling insurance and, therefore, ought to be licensed, whether or not he is a director of the company. It is a fine line.

Mr. CHUMBRIS. The record should not be left with any inference of the fact that you may have this advertising question that the Commissioners of those three States have challenged your doing business in those States.

Mr. SLATER. They are not cease and desist orders. They are a question of "let's get the advertising straightened out," and we are doing that.

Mr. SHARP. Mr. Chumbris, I stated Mr. Slater to be kind enough to supply for the record the States where they are having problems, a

brief description of the problems, and I think it is a fair way of handling this situation at this time.

Mr. SLATER. We will be very happy to do that.

Mr. SHARP. I have two short points, Mr. Chairman. Now, you indicate quite clearly in this statement there is a definite role for small companies, even mail order companies, in the area of supplemental coverage, but isn't the real problem that which you point out in your statement on page 14, the fact that basic comprehensive policies are not available to many Americans because you are not trying to "cream the top," as you say, and that supplemental policies are bought in place of basic coverages. I'll exclude, for example, group programs.

People who are not employed, who are may not be 65; people who are among the 43 million buying individual policies in this country; people working for small proprietors; 5 million small businesses in this country with employees of less than 60. In the insurance industry, sometimes, I understand, they call them "baby groups," so they individually underwrite them. I guess your expression here is they take the cream of the risk.

Suppose everyone could get this comprehensive health insurance in this country, would there be a place for these other types of policies, such as yours?

Mr. SLATER. I think the answer to that question is, as we say, that we think there will always be a need for our particular kind of contract because if they are not filling in their gaps, they are taking care of those expenses incidental to hospitalization.

Now, our company is marketing policies in Canada and we are marketing policies in Great Britain, where they do have national health programs, or supposedly they have complete coverage, and we are in the position where we are selling at a greater rate in those countries than we are in the United States.

Mr. SHARP. What are you selling? Are you selling disability?

Mr. SLATER. We are selling the same products.

Mr. SHARP. You are selling the hospitalization policy?

Mr. SLATER. Yes, sir.

Mr. SHARP. And you are selling the surgical policy? Does it have comprehensive health—

Mr. SLATER. We are selling a hospital policy in Canada and we are also selling a life policy. In England, we are selling, primarily, our hospitalization indemnity policy.

Mr. SHARP. Are you selling in those countries, also, policies to cover outpatient care?

Mr. SLATER. No, sir; we are not.

Mr. SHARP. Extended care?

Mr. SLATER. No, not as yet.

Mr. SHARP. Nursing homes?

Mr. SLATER. Not as yet.

Mr. SHARP. So most of it is still in hospital, inpatient care; is that right?

Mr. SLATER. That's right. We are studying the movement to these other facilities as well.

Mr. SHARP. I would like to close by just reading one case that we have looked at and get your reaction to it, if we may.

This is your file No. 5532546. Now, this person is a 72-year-old male who was interned in the hospital from January 12, to January 20, 1972, for replacement of a pacemaker due to failure of the old pacemaker, accompanying an increasing pulse rate.

The claim was rejected on the basis of preexisting condition as the physician claims it was a condition that existed since 1968.

Now, here is a man who is functioning normally and will need a new pacemaker, like you would need a new dental bridge if your bridgework wore out. Yet you denied his claim on the grounds that the condition had existed since 1968.

This man thought he was—well, he was paying premiums for 15 months. What is your reaction to this kind of insurance?

Mr. SLATER. Here is a man who had a condition existing at least 4 years prior to the time of the claim.

Mr. SHARP. Coronary condition, but not a pacemaker condition.

Mr. SLATER. Well, I think we are being somewhat technical, Mr. Sharp. He would not have the pacemaker if he did not have the coronary problem.

Mr. SHARP. On what basis was it denied: Denied on the basis of a coronary or on the basis of the fact that the pacemaker wore out and he needed a new pacemaker?

Mr. SLATER. Well, if the claim was made because he was in the hospital, it was denied because the condition that existed and the reason he was in the hospital was preexisting at the time that the policy was taken out.

Mr. SHARP. Mr. Chairman, I am wondering if we could put the complete claim files—there aren't that many—that the company has submitted to us into the record at this point.

(Documents follow. Testimony resumes on p. 759.)

FILE No. 5 53 2546

This subject is a 72 year old male confined in the hospital from January 12 to January 20, 1972 for replacement of a pacemaker due to failure of the old pacemaker and accompanying decreasing pulse rate. The claim was rejected on the basis of pre-existing condition since the physician reported that the condition had existed since 1968.

Here is a man who was functioning normally, but he needed a new pacemaker—like you'd need a new dental bridge if your bridgework wore out—yet you denied his claim on the grounds that the *condition* had existed since 1968. And this man thought he was covered while he was paying premiums for 15 months.

What kind of insurance is that?

These introduced into record to be printed.

STATUS WORKSHEET

DEPT #	EMP #	POLICY #	ID	DATE	REG CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESC QUOTE					
703	PEM	5532546	DAN	03/06/72			622526	HOMEH						
DUE DATE		MODE	EFFECTIVE DATE	OCF	PRE BILL	LAST PAID	TYPE	SEX	BIRTH DATE	AGE				
72/04/22		2	70/09/22	9		0	BP3	M	99/09/14	70				
SPEC. REL. HAND CODE	CASH	DATE LAST TRANS	OTHER	PUBLICATION CODE		IFL	MI STAT	LAPSE	PREV LAPSE					
		71/10/26	71/12/03	030-0685-1-19										
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	RATES	SEMI ANNUAL	ANNUAL	ST C	M C				
72/04/04		87.17	00	6.35	18.09	34.29	63.50	12A						
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	MULTI POLICY									
WAIVERS														
DEPENDENTS AND OTHER TRAILERS														
NO	TYPE	NAME			BIRTH DATE	EFF DATE	AGE	RATE	S	RATES				
										MO	QUAR	S	ANIN	ANN
RIDER	TYPE	EFF-DATE	DELET-DATE				RIDER RATES							
	U7	71-09-22				1.60	4.56	8.64	16.00					
PREMIUMS	TRANS-DATE	TYPE	AMOUNT	DUE/UNAP	MTHS	UTYPE								
	71-10-21	85-	34.29	71-10-22	6									
	71-09-21	81-	1.33	71-10-22										
	71-04-15	85-	25.65	71-04-22	6									
	70-10-22	85-	25.65	70-10-22	6									
	70-09-22	84-	.25	70-09-22	1									
MULTI-POLICIES	226983-R	6055144-R	9963454-N											

AUGUSTUS G DANDENAU
 ADDRESS
 502 SUNRISE LANE
 ROCKFORD
 ILL 61107

cl - 2268983
 on out of condition

1968
 4 BNC
 E

DECISION CODE

10	PAY	1	POLICY NUMBER	DATE NOTIFIED	CLAIM NUMBER
20	REJECT - NOT INSURED	6 7	5532546	03/06/72	622526
21	REJECT - NO CONFINEMENT/SURGERY	13 14		19 20	21
22	REJECT - LAPSE DUE PAID	SEX	AGE	DATE OF LOSS	POLICY TYPE
23	REJECT - NOT COVERED (CODE)	M	7 2	0 1 1 2 7 2	BP3
24	REJECT - PRE EXISTING	26	27 28	29	34 35
25	REJECT - WAIVER	DECISION CODE	DIAGNOSTIC CODE		
30	RESCIND	S	3 1	0 3 0 9 7 2	
40	ABANDON	41	42 43 44	51 52	57
50	DUPLICATE	PARTIAL	VOID	DEP	PATIENT NAME (See above)
60	OTHER	COMPLETE	ADD'L	DATE CLOSED	
		58	59 60 61	DA	

1	DAYS	DATE	TIME	AMOUNT	COUNT	1	DUPLICATE	5	6	7	DUPLICATE	13	14	15	
HOS	DAYS				01	16	COMMENTS								21
CONV	DAYS				02	22									35
DR	VISIT				03	36									49
NR	VISIT				04	50									63
DAYS	DIS				05	64									77
SUR					06	78	NAME								88
DIS	MEM				07	89									102
A D					08	103	ADDRESS								114
					09	115									128
					10	129	CITY								140
					11	141									154
					12	155	STATE & ZIP CODE								164
					13	165									178
					14	179	SIGNATURE								189
					15		DATE								
					16		DATE								
					17		DATE								
					18		DATE								
					19		DATE								
					20		DATE								
					21		DATE								
					22		DATE								
					23		DATE								
					24		DATE								
					25		DATE								
					26		DATE								
					27		DATE								
					28		DATE								
					29		DATE								
					30		DATE								
					31		DATE								
					32		DATE								
					33		DATE								
					34		DATE								
					35		DATE								
					36		DATE								
					37		DATE								
					38		DATE								
					39		DATE								
					40		DATE								
					41		DATE								
					42		DATE								
					43		DATE								
					44		DATE								
					45		DATE								
					46		DATE								
					47		DATE								
					48		DATE								
					49		DATE								
					50		DATE								
					51		DATE								
					52		DATE								
					53		DATE								
					54		DATE								
					55		DATE								
					56		DATE								
					57		DATE								
					58		DATE								
					59		DATE								
					60		DATE								
					61		DATE								
					62		DATE								
					63		DATE								
					64		DATE								
					65		DATE								
					66		DATE								
					67		DATE								
					68		DATE								
					69		DATE								
					70		DATE								
					71		DATE								
					72		DATE								
					73		DATE								
					74		DATE								
					75		DATE								
					76		DATE								
					77		DATE								
					78		DATE								
					79		DATE								
					80		DATE								
					81		DATE								
					82		DATE								
					83		DATE								
					84		DATE								
					85		DATE								
					86		DATE								
					87		DATE								
					88		DATE								
					89		DATE								
					90		DATE								
					91		DATE								
					92		DATE								
					93		DATE								
					94		DATE								
					95		DATE								
					96		DATE								
					97		DATE								
					98		DATE								
					99		DATE								
					100		DATE								
					101		DATE								
					102		DATE								
					103		DATE								
					104		DATE								
					105		DATE								
					106		DATE								
					107		DATE								
					108		DATE								
					109		DATE								
					110		DATE								
					111		DATE								
					112		DATE								
					113		DATE								
					114		DATE								
					115		DATE								
					116		DATE								
					117		DATE								
					118		DATE								
					119		DATE								
					120		DATE								
					121		DATE								
					122		DATE								
					123		DATE								
					124		DATE								
					125		DATE								
					126		DATE								
					127		DATE								
					128		DATE								
					129		DATE								
					130		DATE								
					131		DATE								
					132		DATE								
					133		DATE								
					134		DATE								
					135		DATE								
					136		DATE								
					137		DATE								
					138		DATE								
					139		DATE								
					140		DATE								
					141		DATE								
					142		DATE								
					143		DATE								
					144		DATE								
					145		DATE								
					146		DATE								
					147		DATE								
					148		DATE								
					149		DATE								
					150		DATE								
					151		DATE								
					152		DATE								
					153		DATE								
					154		DATE								
					155		DATE								
					156		DATE								
					157		DATE								
					158		DATE								
					159		DATE								
					160		DATE								
					161		DATE								
					162		DATE								
					163		DATE								
					164		DATE								
					165		DATE								
					166		DATE								
					167		DATE								
					168		DATE								
					169		DATE								
					170		DATE								
					171		DATE								
					172		DATE								
					173		DATE								
					174		DATE								
					175		DATE								
					176		DATE								
					177		DATE								
					178		DATE								
					179		DATE								
					180		DATE								
					181		DATE								
					182		DATE								
					183		DATE								
					184		DATE								
					185		DATE								
					186		DATE								
					187		DATE								
					188		DATE								
					189		DATE								
					190		DATE								
					191		DATE								
					192		DATE								
					193		DATE								
					194		DATE								
					195		DATE								
					196		DATE								
					197		DATE								
					198		DATE								
					199		DATE								

National Home Life Assurance Company

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.

Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.

After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner A.G. DANDENAULTPatient SameTelephone 3945114 Age 72

POLICY NUMBER(S)
<u>5532546</u>
<u>7</u>

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

Failure of pacemaker.2. Date of first symptoms: Jan 11th 72 3. Date first treated: Jan 12, 1972

4. Give names and addresses of all physicians who have treated patient during illness or accident:

Dr John Foster 1221 East State Rockford, IllDr. Charles Ballinger 1221 East State St. Rockford, IL5. Name of hospital Swedish AmericanAddress Rockford Illinois6. Dates hospitalized: From Jan 12 To Jan 20th inclusive7. Has this disease caused previous trouble? yes If so, when? 1968 & 1970Treated by: Dr Charles Ballinger & John Foster8. Name of patient's family doctor Dr John FosterAddress of family doctor 1221 East State, Rockford, Ill How long? 4 years

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated Feb 10 1972 CLAIMANT SIGN HERE A.G. DandenaaultClaimant's Address 502 S. RISE LANE City Rockford State ILL Zip Code Approved by: [Signature] ATTENDING PHYSICIAN Degree

PHYSICIAN: PLEASE SIGN

IN THE FOLLOWING PLACES AS INDICATED

- (1) "Patient's Authorization" on reverse side
 (2) At bottom of this form above the perforation

Patient's Name A. S. DANDENAU Age 72

1. Primary Diagnosis(es) Worn out pacemaker.
 Secondary Diagnosis(es) depressed pulse rate
 Complications, if any: _____

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? — Pacemaker
ceased to function on Jan 11th 1972

3. When did patient first have medical attention for this condition? 1968
 By whom? Dr. Ballinger & Dr. J. Foster

4. Has patient ever had same or similar conditions ☒ YES ☐ NO
 If so, give date and describe 1965 + 1970

5. How long have you been patient's family doctor? 4 years.

6. Was patient referred by another doctor? no
 Referring doctor's name and address _____

7. Name of hospital Swedish American
 Address Rockford, Ill 61101
 Dates confined: From Jan 12th To Jan 20th exclusive

8. Nature and charge for surgical procedure Insertion of new pacemaker. DR BALLINGER ¹⁹⁷²
\$ 400.00
 Place performed Swedish American Hosp Date performed Jan 12 1972

9. Dates of medical treatment by you: DR FOSTER 12 charge per call \$ 10.00

OFFICE	HOME	HOSPITAL
<u>Feb 11th 1972</u>	<u>Feb 11th 1972</u>	<u>Days Jan 12 - 20 incl</u>

Date Feb 12 1972 SIGNED DR. Ballinger & Dr. Foster M.D.

Telephone _____ Tax Identification Number _____
 Address 1221 East State
 City ROCKFORD State ILL Zip Code 61101

NATIONAL HOME LIFE ASSURANCE COMPANY • FH1007 • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Raynolds L. Emerson, M.D.
 Medical Director



Attending Physician's Statement

The Rockford Surgical Service, S.C.
1221 East State Street
Rockford, Illinois 61108

1. DANDENAULT, A.G. DR.
2. 502 Sunrise Lane
3. Dandenault, A.G.
4.
5.
6.
7.
8.
9.
10.
11. 1-12-72
12. Re-implant pacemaker with epicardial leads.
13. Heart block.

14. See # 12

15. Swedish American hospital.
16.
17.
18.
19.
20.

1. Insured's Name
2. Address
3. Patient's Name, Age & Relationship
4. Employer
5. Address
6. Insurance Company Name
7. Policy No. and Group No.
8. Address
9. If due to pregnancy give date of conception
10. Date of Accident or Illness
11. History of Accident or Illness
12. Date and Nature of Surgery or Obstetric Procedure
13. Diagnosis

14. Treatment or Service Rendered

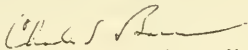
15. Where Performed?
16. If in Hospital, Name of Hospital.
Date of Discharge, "In" or "Out" Patient?
17. If X-Ray taken, by whom? Findings.
18. Date able to return to work. (a) Light (b) Regular
19. Is further treatment anticipated? Explain
20. Remarks

If no further treatment is necessary, itemize charges below:

1-12-72 - Surgery

400.00

Signature of Medical Doctor


Charles S. Ballinger, M.D. Date Signed

February 24, 1972

I hereby authorize payment directly to:

IRS# 36-2615103

Signature of Insured

Date Signed

INSURED

I hereby authorize

to furnish to the
all information which said company

may request concerning my present injury or illness.

Seal

Date

R. GLENN SMITH, M. D.
EDWARD H. SHARP, M. D.
WILLIAM D. COX, M. D.

26 17 E 3/22

A G DANDENAULT M. D.
502 SUNRISE LANE
ROCKFORD, ILL-61107

March 16, 1971

National Home Life Ass. Co.
Valley Forge, Pennsylvania. 1945

Dear Sirs: Re Policy No 2263953

I hereby acknowledge receipt of your check in the amount of \$30⁰⁰ from Policy No 2263953; I also have another policy, No 5532546, with you, for which benefits should be granted. The convalescent Rider 5532546 which is in force reads as follows: "When by reason of injury or sickness, first manifested after the effective date, a covered member is necessarily hospital confined and receives benefits under this policy to which this rider is attached, we will pay the following benefits (amount not stated) beginning on the day shown on the Rider Schedule for such membership commencing following such confinement."

It seems that as long as I am still

convalescing, I am entitled to
benefits from policy no 5532546
as well as hospital benefits;

I believe I told you that my policy
no 2268983 has been misplaced,
will you please send duplicate.

Yours truly

Wanderson

P.S. I was in the Hospital from
January 12th to 20th inclusive
on a total of 9 days.

ALDEN AULT
562 SUNRISE LANE
ROCKFORD, ILL 61107

26-13
pm
5-12

National Home Life Ins. Co.
Valley Forge, Pennsylvania 19451

Dear Mr. Brock,

I hereby acknowledge receipt
of your letter on April 28, 1972;
according to Policy # 5572546,
because of my age, I am entitled
to 50% of the regular \$500⁰⁰
monthly indemnity; I have
previously sent you a copy
of the hospital statement.

Sincerely,
Alden Ault

A. C. A. G. DANDENAULT, M. D.
502 SUNRISE LANE
ROCKFORD, ILL-61107

OF PAID SENT

S. FEB 23 1972

Feb 8 1972

Presidential Life Ins. Co of America
11401 Roosevelt Blvd.
Philadelphia Pa 19154.

Re Policy no 2268983

Dear Sirs.

I was hospitalized in Swedish
American Hospital from Jan 2 to
Jan 20th inclusive -

Yours truly
A. G. Dandenaault.

553254

1972

SWEDISH-AMERICAN HOSPITAL

1316 CHARLES STREET • ROCKFORD, ILLINOIS 61101

NAME DANDENAU, DR. AUGUSTUS G.
 ADDRESS 502 COURSE LAKE
 CITY, STATE ROCKFORD, ILLINOIS 61107

LEDGER NUMBER
 149103

Jan 17

MISCELLANEOUS SERVICES		X-RAY	LAB	MED SUPP	DRUGS	ROOM	DATE	CREDITS		BALANCE	PROOF
1	2							CODE	AMOUNT		
				14.25						1	
				7.60							
				16.50							
ICU	42.00 H			16.25	6.50	40.00	JAN 14 '72			1,866.57	
			26.00	15.00						1	
			22.50	10.50							
				12.60	4.75	47.00	JAN 15 '72			2,004.92	
					4.80	47.00	JAN 16 '72			2,056.72	
3.50 H					4.75	47.00	JAN 17 '72			2,111.57	
	10.00				24.75	47.00	JAN 18 '72	7100		2,193.72	
					1.00	47.00	JAN 19 '72			2,241.72	
					11.57		JAN 20 '72			2,253.29	
				CREDIT	3.50					2	
					24.77						
					26.46		JAN 21 '72			2,301.02	

Please return this hospital statement.

AN ANESTHESIA DAY CARE PSYCHIATRIC DAY CARE RT RESPIRATORY THERAPY XT RADIOACTIVE THERAPEUTIC
 BA BLOOD ADMINISTRATION DR DELIVERY ROOM OR OPERATING ROOM XI RADIOACTIVE DIAGNOSTIC
 BM BILIAL METABOLISM EEG ELECTROENCEPHALOGRAPH PSYTH PSYCHOTHERAPY BC BLUE CROSS
 BS BLOOD SERVICE ERG ELECTROCARDIOGRAM PT PHYSICAL MEDICINE PTPD PAYMENT BY PATIENT
 CONTN CONVULSIVE THERAPY ER EMERGENCY ROOM RR RECOVERY ROOM JV OR RELATIVE ADJUSTMENT

PAY LAST
 AMOUNT SHOWN

1 KACHU & C. INC. 1. 21. 72

ICU 149183
817 1-15-72 1-12-72 1-20-72
10:15AM 1:05 P.M.
DR. FOSTER
SURG. R. CY

DR. AUGUSTUS G. DANDENAULT	SAME
SAME	SELF

682-34-2454-A

79531-15

SELF EMPLOYED PHYSICIAN
1621 BROADWAY BKFD ILL

G-73

230

ICU	42.00	HI	CREDIT--				
				.44			
				.44			
				.55	40.00	JAN 12'72	82.55
236.86	CR						82.5
62.50	AN		31.00				
			10.00				
			33.50	19.20			
				58.45			
				7.36			
				1.90			
				14.85			
			NO.5942 MEOTRONIC-----	929.50			
				7.50			
				23.25	19.40	40.00	JAN 13'72
ICU	42.00	HI	11.00			7100	1,619.82
27.00	IN					7100	1,619.8
EKG	14.00	HI	11.00	27.50			
				13.15	JAN 14'72		1,723.47

1-2
Медсан 4 ОБС. 1.26.72

FILE No. 5 61 0929

This case shows that the company obtains information from the Veterans' Administration in that it requested and received information from the Veterans' Administration Hospital in Portland, Oregon.

It should be noted that on the VA reply the warning is stamped not to disclose this information to the veteran or his representative, since it has been medically determined that disclosure may be injurious to the veteran's physical or mental health.

NAME AND ADDRESS OF PATIENT George Fickisen 0		5610929		03	29	71	H084636
POLICY NUMBER		DATE, NOTIFIED		CLAIM NO.			
DATE OF LOSS		SEX	AGE	TYPE			
03 03 71		M	45	BDN		S	
NO. DAY YR.				CODE SYMBOLS			
FOLLOW UP		ADJUSTOR		WANTED			
				Auth. Needed			
				Claim Form P.O. Side			
				Claim Form DR Side			
				Hospital Records			
				Hospital Bill			
				Staff Letter			
				15 DL Letter			
				Retail Credit			
				See Instructions			

SPECIAL INSTRUCTIONS:

10 <input type="checkbox"/> PAY	
11 <input type="checkbox"/> PAY - WAY BEFORE PAY	
12 <input type="checkbox"/> PAY - WAY AFTER DEC	
21 <input type="checkbox"/> REJ. - NO CONTINEMENT	
22 <input type="checkbox"/> REJ. - POLICY LAPSE	
23 <input type="checkbox"/> REJ. - NOT INSURED / COVER	
24 <input checked="" type="checkbox"/> REJ. - PRE EXISTING	
25 <input type="checkbox"/> REJ. - COVERED	
30 <input type="checkbox"/> RESCIND	
40 <input type="checkbox"/> ABANDON	
50 <input type="checkbox"/> DUPLICATE	
60 <input type="checkbox"/>	
<input type="checkbox"/> LE	
<input type="checkbox"/> NON-LE	

nasal trauma 1910 8

NATIONAL HOME LIFE ASSURANCE CO.

CLOSING

MO. DAY YR.	<input type="checkbox"/> YES	<input type="checkbox"/> PARTIAL	MO. DAY YR.	
4 6 71	<input type="checkbox"/> NO	<input type="checkbox"/> COMPLETE		
DIAGNOSTIC CODE	DATE CLOSING	WAIVER ADDED	ADD'L	DRAFT NO.
BASE				
Hosp. Days at	/			
Conv. Days at	/			
Dr. visits at	/			
Nurse visits at	/			
Days Dis. Inc. at	/			
Surgery				
Dismemberment				
Accidental Death				
RIDER				
Hosp. Days at	/			
Conv. Days at	/			
Dr. visits at	/			
Nurse visits at	/			
Days Dis. Inc. at	/			
Surgery				
Dismemberment				
Accidental Death				

01 ☒ PAYEE AS ABOVE

02

03 ☐ OTHER

04

05 NAME AND ADDRESS

06

07

08

31

32

33

34

35

36

37

38

Adjustor No.

National Home Life Assurance Company

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.

Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.

After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner <u>George E. Fickisen</u>	POLICY NUMBER(S) <u>5610929</u>
Patient <u>George E. Fickisen</u>	
Telephone <u>586-9950</u> Age <u>45</u>	

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

2. Date of first symptoms: JAN. 1968 3. Date first treated: 1968

4. Give names and addresses of all physicians who have treated patient during illness or accident:

RAINIER CLINIC 14TH AVE. S. SEATTLE WASHINGTON

TREATED BY DR. THOMAS HENH

DR. H.L. CAHN 750 SWIFT BLVD RICHLAND, WASHINGTON NOV 1970

5. Name of hospital U.S.V.A. HOSPITAL

Address SAM JACKSON PARK PORTLAND, OREGON

6. Dates hospitalized: From MARCH 3, 1971 To MARCH 11, 1971

7. Has this disease caused previous trouble? Yes If so, when? 1968

Treated by: DR. H.L. CAHN

8. Name of patient's family doctor DR. H.L. CAHN

Address of family doctor 2118 HARRIS, RICHLAND, WASH. How long? _____

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated 3-26- 19 71 CLAIMANT SIGN HERE George E. Fickisen

Claimant's Address 1301 W. FALLS AVE City KENNEWICK State WASHINGTON Zip Code 99331

Approved by: _____ Degree _____

ATTENDING PHYSICIAN

**PHYSICIAN: PLEASE SIGN
IN THE FOLLOWING PLACES AS INDICATED**

- (1) "Patient's Authorization" on reverse side
(2) At bottom of this form above the perforation

Patient's Name _____ Age _____

1. Primary Diagnosis(es) _____

Secondary Diagnosis(es) _____

Complications, if any: _____

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? _____

3. When did patient first have medical attention for this condition? _____

By whom? _____

4. Has patient ever had same or similar conditions ☐ YES ☐ NO

If so, give date and describe _____

5. How long have you been patient's family doctor? _____

6. Was patient referred by another doctor? _____

Referring doctor's name and address _____

7. Name of hospital _____

Address _____

Dates confined: From _____ To _____

8. Nature and charge for surgical procedure _____

\$ _____

Place performed _____ Date performed _____

charge per call \$ _____

9. Dates of medical treatment by you:

OFFICE

HOME

HOSPITAL

Date _____ SIGNED _____ M.D.

Telephone _____ Address _____

City _____ State _____ Zip Code _____

NATIONAL HOME LIFE ASSURANCE COMPANY • CFH082 • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Reynolds L. Emerson, M.D.
Medical Director



FICKISEN, GEORGE ERNEST 44 M W 99 144 998 212 22 3848 VAH PORTLAND, OREGON

X 1. Nasal deformity secondary to trauma.

Not to be Disclosed to the
Veteran or his Representative.

Rhinoplasty

It has been medically determined
disclosure, of this information may
be injurious to the claimant's
physical or mental health.

3/8/71

This is a 44 year old white male with a history of nasal trauma in 1964 and since then has had left sided nasal obstruction. The patient is very anxious and tense over this and seems to have a considerable amount of mental and physical time and effort spent on worrying about his nose. Past medical history revealed no serious medical and surgical illnesses. No drug allergies and no routine medications. The ENT examination showed the tympanic membranes, canals and tuning fork test to be within normal limits. The nose showed a traumatic loss of the left upper lateral cartilage with partial collapse in this area. Just inside the vestibula on the left there was a synechia and scar tissue tending to cause a stenosis of the nasal vestibule. There was no pus in the nose. Patient had a broad inferior septum also. Observing the patient on notices almost chronic finger to nose activity. The nasopharynx, mouth, larynx, hypopharynx, neck, thyroid and cranial nerves 3,4,6, and 7 were all normal. Nasal sinus films were negative.

Hospital course: The patient was seen preoperative by Dr. Phillip Andrews a plastic surgeon consultant at the Portland VA Hospital. His screening laboratory values were within normal limits. Patient's chest film and sinus xrays were normal and EKG was normal. On the eighth of March 1971 he underwent a rhinoplasty with special emphasis on the stenosis in the vestibular area. His postoperative course was uneventful. The patient was discharged with his packs and rhinoplasty dressing in place. Prior to discharge however he was cautioned and instructed very extensively by Dr. Eschelmann against smoking and was given signs and symptoms on which to recur before the scheduled clinic date. He will be seen OPT-NSC in ENT Clinic.

3/3/71

3/11/71

OPT-NSC

1-B

ROBERT L. MOESINGER, M.D.



VETERANS ADMINISTRATION
HOSPITAL
SAM JACKSON PARK
PORTLAND, OREGON 97207

March 26, 1971

YOUR FILE REFERENCE:

IN REPLY REFER TO: 648/136B/cn
PICKISEN, GEOR ERNEST
212 22 3848

National Home Life Assurance Company
Adm. Offices
Valley Forge, Pennsylvania 19481

A request to furnish you information concerning the above-named veteran has been received.

The following checked item is applicable to this request:

- ☐ We are unable to identify this individual. If you can furnish additional information - such as claim number, date of birth, and approximate date of admission and/or discharge - and verify spelling of the name, we shall be glad to make another search.
- ☐ Medical information is confidential and may be released only upon written consent of the veteran concerned. If you will present an authorization or a photostatic copy thereof signed and dated subsequent to the treatment period covered, we shall act on your request. Should you not have the authorization on file, we suggest you use the enclosed consent form.
- ☐ Copies of the records requested may not be released without a charge of \$. We shall send them upon receipt of a check for this amount. Checks should be made payable to the Veterans Administration; please include on the check the veteran's name and claim number or address, as well as the explanation, "For medical information." A stamped self-addressed envelope should also be furnished.
- ☒ The information requested is enclosed. Since this information is privileged, its confidentiality should be maintained. Additional information necessary for treatment purposes will be furnished upon request. This letter is not to be construed as a request to render medical service to the veteran at the expense of the Veterans Administration.
- ☐

Very truly yours,

ROBERT D. ROWEN, Assistant Chief
Medical Administration Division

FL 10-286
FEB 1965(RS)

Show veteran's full name and VA file number on all correspondence. If VA number is unknown, show service number.

STATUS REPORT

DEPT #	EMP #	POLICY #	ID	DATE	REG #	CLAIM REASON	CLAIM #	
1625	0019	5610929	FIC	03/29/11	4			
DUE DATE	MODE	EFFECTIVE DATE	OCF	PRE BILL	PREV BILL	TYPE	SEX	
71/07/23	4	10/10/13	9	000		BIN	M	
BIRTH DATE	AGE							
25/02/22	45							
DATE LAST TRANS	OTHER	PUBLICATION CODE	IFL	MI STAT	LAPSE	PREV LAPSE		
71/03/24	71/03/24	243-0509-1-1				0		
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	SEMI ANNUAL	ANNUAL	
71/07/05		39.66	00	6.45	18.38	34.83	64.50	
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	MULTI-POLICY			
WAIVERS								

DEPENDENTS AND OTHER TRAILERS										
NO	TYPE	NAME	BIRTH DATE	EFF DATE	AGE	RATE \$	MO	GUAR	S ANN	ANN
NO DEPENDENTS										
OTHER TRAILERS										
A76	710113	710113				0.00				
E	2.20	6.27	11.88	22.00						
DATE	TRAN	DOCU	AMOUNT	FROM	TO	U DATE	U TR	U DOC		
1013	84		0.25	701013	701113					
1117	85	5323	4.25	701113	701213					
1217	85		4.25	701213	710113					
0118	81	0112	1.83		710113					
0118	85	0113	4.25	710113	710213					
0316	23									
0323	67			710213	710323					
0323	85	2279	6.45	710323	710423					
0324	85	2218	18.38	710423	710723					
0324	09	2218		49DN00645018380348306450						

Effective Date of Change

Check Payable to:

YR	MO	DA	Transaction Code	Location	Reference No.
13	14	15	16	17	18
19	20	21	22	23	24
25	26	27	28	29	30

Check Route

____ NLL

____ Main Insured

____ Estate of MI

Field A - New Field NOTE "@" sign must follow last character on transaction #1 only

31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Field B - Old Field NOTE "@" sign must follow last character on transaction #1 only

56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Explanation

Approved by

Prepared by

date

FILE NO. 5 59 5729

This subject is a 72 year old male who was confined in the hospital from January 4 to January 16, 1972 and who had had hospital insurance in effect with this company since October 1970. The subject was confined in the hospital for extraction of cataracts of both eyes which were removed by one physician, and for treatment of cardio-vascular disease by a second physician. The first physician indicated that symptoms of cataracts was first noticed in December 1971. The second physician indicated that he had done an electrocardiogram on this patient in December of 1971.

The physician's statement would indicate that there was no pre-existing condition. The company then contacted the hospital requesting information after having received the physicians' reports and the hospital advised the company that there had been gradual loss of vision for the past 2 years.

The company then rejected this claim on the basis of a pre-existing condition.

STATUS WORKSHEET

DEPT #	EMP #	POLICY #	ID	DATE	REG CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESC QUOTE
DUE DATE	MODE	EFFECTIVE DATE	OCF	PRE BILL	LAST DO NOT BILL BY	TYPE	SEX	BIRTH DATE	AGE
SPEC REL HAND CODE	CASH	DATE LAST TRANS	OTHER	PUBLICATION CODE	IFL	MI STAT	LAPSE	PREV LAPSE	NAME
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	RATES	SEMI ANNUAL	ANNUAL	ST I A C
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	MULTI POLICY				
WAIVERS									
DEPENDENTS AND OTHER TRAILERS									
NO	TYPE	NAME				BIRTH DATE	EFF DATE	AGE	RATES
									MO GUAR S ANN ANN

DECISION CODE

10	PAY	POLICY NUMBER		DATE NOTIFIED		CLAIM NUMBER	
20	REJECT - NOT INSURED	1					
21	REJECT - NO CONFINEMENT/SURGERY	6	7	13	14	19	20
22	REJECT - LAPSE DUE PAID	SEX	AGE	DATE OF LOSS		POLICY TYPE	ADJUSTER NO
23	REJECT - NOT COVERED (CODE)	26	27	28	29	34	35
24	REJECT - PRE EXISTING	DECISION CODE		DIAGNOSTIC CODE		DATE CLOSED	
25	REJECT - WAIVER						
30	RESCIND	41	42	43	44	51	52
40	ABANDON	VOID DEF		PATIENT NAME (See above)			
50	DUPLICATE	<input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE <input type="checkbox"/> ADD'L		ID CODE			
60	OTHER	58	59	60	61	85 86 88	

1	DAYS	REASON	TIME	AMOUNT	COUNT	1	DUPLICATE	5	6	7	DUPLICATE	13	14	15
HOS DAYS						01								
CONV DAYS						02	16	COMMENTS						21
DR VISIT						03	22							35
NR VISIT						04								
DAYS DIS						05	36							49
SUR						06	50							63
DIS MEM						07								
A D						08	64							77
NO DAYS						09	78							88
NO DAYS						10	89							102
CONV DAYS						11	103							114
DR VISIT						12	115							128
NR VISIT						13	129							140
DAYS DIS						14	141							154
SUR						15	155							164
DIS MEM						16	165							178
A D						17	179							189
NO DAYS						18	16	COMMENTS						21
CONV DAYS						19	22							35
DR VISIT						20	36							49
NR VISIT						21	50							63
DAYS DIS						22	64							77
SUR						23	78							88
DIS MEM						24	89							102
A D						25	103							114
NO DAYS						26	115							128
CONV DAYS						27	129							140
DR VISIT						28	141							154
NR VISIT						29	155							164
DAYS DIS						30	165							178
SUR						31	179							189
DIS MEM						32	16	COMMENTS						21
A D						33	22							35
NO DAYS						34	36							49
CONV DAYS						35	50							63
DR VISIT						36	64							77
NR VISIT						37	78							88
DAYS DIS						38	89							102
SUR						39	103							114
DIS MEM						40	115							128
A D						41	129							140
NO DAYS						42	141							154
CONV DAYS						43	155							164
DR VISIT						44	165							178
NR VISIT						45	179							189
DAYS DIS						46	16	COMMENTS						21
SUR						47	22							35
DIS MEM						48	36							49
A D						49	50							63
NO DAYS						50	64							77
CONV DAYS						51	78							88
DR VISIT						52	89							102
NR VISIT						53	103							114
DAYS DIS						54	115							128
SUR						55	129							140
DIS MEM						56	141							154
A D						57	155							164
NO DAYS						58	165							178
CONV DAYS						59	179							189
DR VISIT						60	16	COMMENTS						21
NR VISIT						61	22							35
DAYS DIS						62	36							49
SUR						63	50							63
DIS MEM						64	64							77
A D						65	78							88
NO DAYS						66	89							102
CONV DAYS						67	103							114
DR VISIT						68	115							128
NR VISIT						69	129							140
DAYS DIS						70	141							154
SUR						71	155							164
DIS MEM						72	165							178
A D						73	179							189
NO DAYS						74	16	COMMENTS						21
CONV DAYS						75	22							35
DR VISIT						76	36							49
NR VISIT						77	50							63
DAYS DIS						78	64							77
SUR						79	78							88
DIS MEM						80	89							102
A D						81	103							114
NO DAYS						82	115							128
CONV DAYS						83	129							140
DR VISIT						84	141							154
NR VISIT						85	155							164
DAYS DIS						86	165							178
SUR						87	179							189
DIS MEM						88	16	COMMENTS						21
A D						89	22							35
NO DAYS						90	36							49
CONV DAYS						91	50							63
DR VISIT						92	64							77
NR VISIT						93	78							88
DAYS DIS						94	89							102
SUR						95	103							114
DIS MEM						96	115							128
A D						97	129							140
NO DAYS						98	141							154
CONV DAYS						99	155							164
DR VISIT						100	165							178
NR VISIT						101	179							189
DAYS DIS						102	16	COMMENTS						21
SUR						103	22							35
DIS MEM						104	36							49
A D						105	50							63
NO DAYS						106	64							77
CONV DAYS						107	78							88
DR VISIT						108	89							102
NR VISIT						109	103							114
DAYS DIS						110	115							128
SUR						111	129							140
DIS MEM						112	141							154
A D						113	155							164
NO DAYS						114	165							178
CONV DAYS						115	179							189
DR VISIT						116	16	COMMENTS						21
NR VISIT						117	22							35
DAYS DIS						118	36							49
SUR						119	50							63
DIS MEM						120	64							77
A D						121	78							88
NO DAYS						122	89							102
CONV DAYS						123	103							114
DR VISIT						124	115							128
NR VISIT						125	129							140
DAYS DIS						126	141							154
SUR						127	155							164
DIS MEM						128	165							178
A D						129	179							189
NO DAYS						130	16	COMMENTS						21
CONV DAYS						131	22							35
DR VISIT						132	36							49
NR VISIT						133	50							63
DAYS DIS						134	64							77
SUR						135	78							88
DIS MEM						136	89							102
A D						137	103							114
NO DAYS						138	115							128
CONV DAYS						139	129							140
DR VISIT						140	141							154
NR VISIT						141	155							164
DAYS DIS						142	165							178
SUR						143	179							189
DIS MEM						144	16	COMMENTS						21
A D						145	22							35
NO DAYS						146	36							49
CONV DAYS						147	50							63
DR VISIT						148	64							77
NR VISIT						149	78							88
DAYS DIS						150	89							102
SUR						151	103							114
DIS MEM						152	115							128
A D						153	129							140
NO DAYS						154	141							154
CONV DAYS						155	155							164
DR VISIT						156	165							178
NR VISIT						157	179							189
DAYS DIS						158	16	COMMENTS						21
SUR						159	22							35
DIS MEM						160	36							49
A D						161	50							63
NO DAYS														

National Home Life Assurance Company

A FEB 22 1972 10 22 AM

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.

Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.

After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner Vernon W Perrigo MA POLICY NUMBER(S) 559-572-9
 Patient Vernon W Perrigo
 Telephone 45-33991 Age 72

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

Cataract on both eyes Dr. Kopf
+ nervous heart Dr. Bateman

2. Date of first symptoms: 5 or 6 mo ago 3. Date first treated: Jan. 4th

4. Give names and addresses of all physicians who have treated patient during illness or accident:

Dr. George Kopf Assistant Below
Operated Kopf Dr. Letoage
Dr. Mangan

5. Name of hospital Bethesda Dr. Bateman New Sp
 Address Maple Ave Janitorial Ohio

6. Dates hospitalized: From Jan 4th To Jan 16th

7. Has this disease caused previous trouble? none If so, when?

Treated by: none

8. Name of patient's family doctor Dr. Bateman

Address of family doctor Bell St How long? mo ago

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
 ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired

Dated 2-1-72 19 CLAIMANT SIGN HERE Vernon W Perrigo

Claimant's Address _____ City _____ State _____ Zip Code _____

Approved by: _____ Degree _____

ATTENDING PHYSICIAN

PHYSICIAN: PLEASE SIGN
IN THE FOLLOWING PLACES AS INDICATED.

- (1) "Patient's Authorization" on reverse side
(2) At bottom of this form above the perforation

Patient's Name Vernon Perrigo Age 72

1. Primary Diagnosis(es) bilateral cataracts

Secondary Diagnosis(es) _____

Complications, if any: _____

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? 12/29/71

3. When did patient first have medical attention for this condition? 12/29/71

By whom? George M. Kopf M.D.

4. Has patient ever had same or similar conditions ☐ YES ☒ NO

If so, give date and describe _____

5. How long have you been patient's family doctor? since 12/29/71

6. Was patient referred by another doctor? no

Referring doctor's name and address _____

7. Name of hospital Bethesda Hospital

Address Zanesville, Ohio

Dates confined: From 1/4/72 To 1/16/72

8. Nature and charge for surgical procedure Intracapsular cataract extraction, bilateral

\$ 800.00

Place performed Bethesda Hospital, Zanesville Date performed 1/6, 1/12/72

9. Dates of medical treatment by you: charge per call \$ _____

OFFICE

HOME

HOSPITAL

Date 2/18/72 SIGNED George M. Kopf M.D.

Tax Identification Number _____

Telephone 453-0715 Address 2315 Maple Ave.

City Zanesville State Dhio Zip Code 43701

NATIONAL HOME LIFE ASSURANCE COMPANY • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

D541-771

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Reynolds L. Emerson, M.D.
Medical Director



107: 5

W. C. C. 43791

NO. OF
LAYS

DISCHARGE

[illegible]

POLICY NUMBER _____ CONTAINER'S INITIALS, DATE & TIME

RECORD REQUEST

FORM NEEDED	RECORD REQUEST
AUTHORIZATION	INFO
CLM. FORM - PO	INFO
CLM. FORM - DO	INFO
HOSPITAL BILL	INFO. STATUS REG
TO WHAT AG. FOLLOW-UP	SNAP - INT
RETAIL CREDIT	11 TO LATER - 24 - 8

HOSPITAL *Lithia Springs*

RECORDS *1-4-72*

614-452-4535

PHYSICIAN INFORMATION

RES *C 2#1a contacts*
DE. *Raf + 12/11/71* *(2) R#3 cardio-vascular ill.*

H & C FS

DE. _____

SPECIAL FS

DE. _____

PHYSICIAN REQUEST EXAMINER

3/5 JH *10*
DATE RECORD REQUEST COMPLETED

**NATIONAL HOME
HEALTH
PLAN.**

Dr. G. Kopf
2315 Maple Ave
Zanesville OH 43701

Date Jan 3-1-72 404

Patient's Name Vernon Perrico

Address 1239 Race St

Zanesville OH 43701

File No 5585729 *12nd*

Dear Doctor:

We would appreciate your assistance in processing our policyowner's request for benefits. The above named patient indicated that you treated him (or her) prior to a recent hospital confinement. Please answer the following:

1. According to your records and the history obtained from the patient, when were signs or symptoms of cataracts first noticed? Patient first examined here 12/29/71

2. In your opinion, approximately what percentage of or how many days of the patient's confinement may be attributed to the treatment of cardio-vascular disease? *none*

Date ^c 3/15/72

Signed *Leah Kopf*

This letter is being sent to you in duplicate so you will have a copy for your file. (Sign and date one copy before returning).

We do appreciate your assistance in this matter and a pre-paid envelope is enclosed for your convenience. Should you request it, we would be willing to pay a reasonable clerical fee for the time involved.

Sincerely,

R. E. Watters

REW:rt
D480-971

R. E. Watters
Claim Department

**NATIONAL HOME
HEALTH
PLAN.**

Dr. Bateman
Bell St
Zanesville OH

Date Jul 3-1-72 404

Patient's Name Vernon Perrigo

Address 1230 Race St

Zanesville OH 43701

File No. 5585720

Dear Doctor:

We would appreciate your assistance in processing our policyowner's request for benefits. The above named patient indicated that you treated him (or her) prior to a recent hospital confinement. Please answer the following:

1. According to your records and the history obtained from the patient, when were signs or symptoms of cataracts first noticed?
2. In your opinion, approximately what percentage of or how many days of the patient's confinement may be attributed to the treatment of cardio-vascular disease?

I read an electrocardiogram on this patient on 12-29-71.

Summary: T wave changes suggest myocardial disease.

Multifocal VPC's.

This patient was referred to me from G. M. Kopf, M. D. The EKG interpretation is the only record I have for this patient.

Date 3-14-72

Signed R. E. Watters

This letter is being sent to you in duplicate so you will have a copy for your file. (Sign and date one copy before returning).

We do appreciate your assistance in this matter and a pre-paid envelope is enclosed for your convenience. Should you request it, we would be willing to pay a reasonable clerical fee for the time involved.

Sincerely,

R. E. Watters

REW:rt
D480-971

R. E. Watters
Claim Department

POLICY NUMBER

EXAMINER'S INITIALS, DATE & TIME

RECORD REQUEST

X	FORM NEEDED	RECORD REQUEST
	AUTHORIZATION	INFO
	CLM. FORM - PO	15 DL
	CLM. FORM - DR	SMR
	HOSPITAL BILL	HOSP. STATUS REG.
	TO WATS FOR FOLLOW-UP	SNAP OUT
	RETAIL CREDIT	FLEXO LETTER - 24 - 8
X	HOSPITAL RECORDS <i>Dep</i>	

DOCTOR INFORMATION

<u>R2S</u> Dr. -----
<u>H & C 2S</u> Dr. -----
<u>SPECIAL 2S</u> Dr. -----
RETURN FILE TO EXAMINER

3-24-72 2:00 PM
DATE RECORD REQUEST COMPLETED

National Home Life Assurance Company / Admin

DATE OF BIRTH 05/07/14

NO 107503-0

DELINCOA HOSP
CHENESVILLE
OH

CHECK AMOUNT \$444.00

NON - NEGOTIABLE
9015726

JOHN PERALTA JR
1034 N. CONELL AVE
DULLES
CALIF 95015

Date: 02/07/72
Policy No. 5042423
Entered Hospital: 02/04/72

Medical Record Librarian:

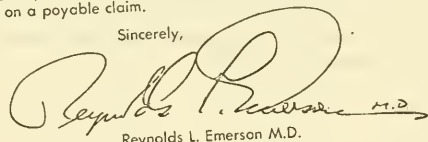
Would you please send us a copy of your records pertaining to the above named patient, who is awaiting disposition of a claim that has been filed with us.

The following information is necessary to the prompt handling of this claim: 1. Admission Sheet, 2. History of Present Illness, 3. Post Medical History Sheet and Physical Examination or Review of Systems, 4. Discharge Summary and 5. Dates and Diagnoses of Prior Admissions.

We appreciate your cooperation on behalf of your patient, our policy-owner. We have enclosed the patient's authorization, postpaid reply envelope as well as our bank draft to cover your services.

Your immediate attention will enable us to resolve your patient's claim more quickly, and of course, we will honor any appropriate assignment of benefits you might have on a payable claim.

Sincerely,



Reynolds L. Emerson M.D.
Medical Director

RLE/af
D755-671-5

Enclosures: Authorization
Return Envelope

SECOND REQUEST



BETHESDA HOSPITAL

2951 MAPLE AVENUE • ZANESVILLE, OHIO 43701 • TELEPHONE 614-452-4535

March 17, 1972

National Home Health Plan
National Home Life Assurance Co.
Valley Forge, Pennsylvania 19481

Re: Vernon Wayne Perrigo
Policy No: 559211

Dear Sirs:

The above named individual was admitted to Bethesda Hospital on 1-4-72 under the care of G. M. Kopf, M.D.

The present history states as follows: Gradual loss of vision, OD past two years, also gradual loss of vision OS past two years. No known allergies to drugs, no present medications, no previous surgeries.

On 1-6-72 G. M. Kopf, M.D. performed a Intracapsular cataract extraction, right eye and on 1-12-72 a Intracapsular cataract extraction, left eye on the patient.

Mr. Perrigo was discharged on 1-16-72 with the final diagnosis of: Cataracts, O.U. Arteriosclerotic heart disease.

The above information was taken from the medical records of Vernon Wayne Perrigo on March 17, 1972.

Sincerely,

Margaret Godby

Margaret Godby
Medical Records Department
Bethesda Hospital

CLAIMANT'S TELEPHONE SHEET

CLAIMANT _____ POLICY NO. _____
ADDRESS _____
(Street) _____ (City) _____ (State) _____

To Be Called:	Telephone No.	Date In	Message	Date Out
HOSPITAL			<input type="checkbox"/> Already Sent <input type="checkbox"/> Incomplete <input type="checkbox"/> Will Send Today or Tomorrow A.S.A.P. <input type="checkbox"/> Send Duplicate Request	
<i>Bedside</i>				
<i>Sanctuary 17</i>				
DOCTOR			<input type="checkbox"/> Already Sent <input type="checkbox"/> Incomplete <input type="checkbox"/> Will Send A.S.A.P. <input type="checkbox"/> Dup. Req.	
RETAIL CREDIT				
OTHER			<input type="checkbox"/> Sent <input type="checkbox"/> Sent to Dr. or Hosp. <input type="checkbox"/> Send Dup.	

FILE No. 5 58 0623

This patient is a 50 year old female who was confined in the hospital from February 18, 1972 to March 17, 1972. The subject had had insurance with the company since October of 1970. The reason for admission to the hospital was obesity and congestive heart failure. In answer to the company's first inquiry to the physician as to the nature of the illness, the physician reported on April 17, 1972, that the patient was admitted for obesity and congestive heart failure and that the congestive heart failure was a new diagnosis, not pre-existing. The company recontacted the doctor and requested his opinion on how many days of the patient's confinement could be contributed to the treatment of obesity. The doctor replied on May 15, 1972, that there was no way to separate the conditions: i.e., congestive heart failure and obesity. The company then rejected the claim on the grounds of a pre-existing condition; namely, that the lady was obese prior to the time she purchased the policy.

STATUS WORKSHEET

DEPT #	EMP #	POLICY #	ID	DATE	REC CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESC QUOTE				
				PRE BILL	LAST BILL	DATE	TYPE	SEX	BIRTH DATE	AGE			
DUE DATE		MODE	EFFECTIVE DATE	OCP	PUBLICATION CODE		IFL	MI STAT	LAPSE	PREV LAPSE			
SPEC HAND	REF	DATE LAST TRANS	CASH	OTHER	PUBLICATION CODE		IFL	MI STAT	LAPSE	PREV LAPSE			
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	RATES	SEMI ANNUAL	ANNUAL	ST C	MA C			
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	MULTI-POLICY								
WAIVERS													
DEPENDENTS AND OTHER TRAILERS													
NO	TYPE	NAME				BIRTH DATE	EFF DATE	AGE	RATE \$	RATES			
										MO	QUAR	S ANN	ANN

DECISION CODE

10	PAY	1	POLICY NUMBER	DATE NOTIFIED	CLAIM NUMBER
20	REJECT - NOT INSURED	6 7	13 14	19 20	21
21	REJECT - NO CONFINEMENT/SURGERY	SEX	AGE	DATE OF LOSS	POLICY TYPE
22	REJECT - LAPSE DUE PAID	26	27 28	29	34 35
23	REJECT - NOT COVERED (CODE)	DECISION CODE	DIAGNOSTIC CODE	DATE CLOSED	ADJUSTER NO
24	REJECT - PRE EXISTING	41	42 43	44	51 52
25	REJECT - WAIVER	VOID	DEP #	PATIENT NAME (See above)	60' COD
30	RESCIND	58	59 60	61	85 86 87
40	ABANDON				
50	DUPLICATE				
60	OTHER				

1	DAYS	WAGE	TIME	AMOUNT	COPIES	1	DUPLICATE	5	6/7	DUPLICATE	13	14	15
HOS	DAYS				01	16	COMMISSION						21
CONV	DAYS				02	22							35
DR	VISIT				03	36							49
NR	VISIT				04	50							63
DAYS	DIS				05	64							77
SUR					06	78	SMR						88
DIS	MEM				07	89							102
A D					08	103	COMMISSION						114
REASON #4					19	115							128
HOS	DAYS				31	129							140
CONV	DAYS				32	141							154
DR	VISIT				33	155	SMR						164
NR	VISIT				34	165							178
DAYS	DIS				35	179							189
SUR					36								
DIS	MEM				37								
A D					38								
REASON #5					39								
DRAFT #1 AMOUNT					209	215	179						189
2	DAYS	WAGE	TIME	AMOUNT	COPIES <td>1</td> <td>DUPLICATE</td> <td>5</td> <td>6/7</td> <td>DUPLICATE</td> <td>13</td> <td>14</td> <td>15</td>	1	DUPLICATE	5	6/7	DUPLICATE	13	14	15
HOS	DAYS				01	16	COMMISSION						21
CONV	DAYS				02	22							35
DR	VISIT				03	36							49
NR	VISIT				04	50							63
DAYS	DIS				05	64							77
SUR					06	78	SMR						88
DIS	MEM				07	89							102
A D					08	103	COMMISSION						114
REASON #4					19	115							128
HOS	DAYS				31	129							140
CONV	DAYS				32	141							154
DR	VISIT				33	155	SMR						164
NR	VISIT				34	165							178
DAYS	DIS				35	179							189
SUR					36								
DIS	MEM				37								
A D					38								
REASON #5					39								
DRAFT #2 AMOUNT					209	215	179						189
REASON #1 (90-106)	REASON #2 (107-123)	REASON #3 (124-140)	REASON #4 (141-174)	REASON #5 (175-208)	HIGH CHARGES								
RETURN CHECK(S) TO					BE(S)M TO					SMR	DRAFT #1	\$	
					ANC TO					BE(S)H	DRAFT #2	\$	
											DRAFT #3	\$	
											TOTAL AMOUNT THIS CLAIM	\$	

National Home Life Assurance Company

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.

Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.

After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner Elizabeth A. Champion
Patient Same
Telephone 224-1446 Age 51

POLICY NUMBER(S)
<u>5-10-11</u>
<u>NH</u>

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

Heart - breathing difficulty, Distress

2. Date of first symptoms: Feb 17, 1972 3. Date first treated: 2-18-72

4. Give names and addresses of all physicians who have treated patient during illness or accident:

Dr. B.S. Bivley
Dr. J. J. Salemi
Dr. W. J. Bivley

5. Name of hospital Richard General Medical Center

Address 100 So. Andrews Ave., Ft. Lauderdale, Fla. 33304

6. Dates hospitalized: From Feb 18, 1972 To March 17, 1972

7. Has this disease caused previous trouble? Yes If so, when? 1968

Treated by: Same

8. Name of patient's family doctor Dr. Bivley

Address of family doctor 501 2nd Ave. S.W. How long? 10 years

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
AOL OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated 2-23-72 19 72 CLAIMANT SIGN HERE Elizabeth A. Champion

Claimant's Address 412 S. E. 9th Ave. City Ft. Lauderdale State Fla. Zip Code 33311

Approved by: NH ATTENDING PHYSICIAN Degree

PHYSICIAN: PLEASE SIGN

IN THE FOLLOWING PLACES AS INDICATED

- (1) "Patient's Authorization" on reverse side
 (2) At bottom of this form above the perforation

Patient's Name Betty Champion Age 48

1. Primary Diagnosis(es) Obesity; congestive heart failure.
 Secondary Diagnosis(es) Diabetes
 Complications, if any: _____

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? few years ago

3. When did patient first have medical attention for this condition? 7-11-67
 By whom? B. R. Birely, M.D.

4. Has patient ever had same or similar conditions ☐ YES ☒ NO
 If so, give date and describe _____

5. How long have you been patient's family doctor? 1967

6. Was patient referred by another doctor? no
 Referring doctor's name and address _____

7. Name of hospital Broward General Medical Center
 Address 1600 South Andrews; Fort Lauderdale, Florida
 Dates confined: From 2-18-72 To 3-17-72

8. Nature and charge for surgical procedure _____
 \$ _____

Place performed _____ Date performed _____

9. Dates of medical treatment by you: _____ charge per call \$ _____

☐ OFFICE ☒ HOME ☐ HOSPITAL

Date 3-25-72 SIGNED [Signature] Identification Number 59 1279835 M.D.

Tax Identification Number _____

Telephone _____ Address 837 N.E. 20 Avenue
 City Fort Lauderdale State Florida Zip Code 333-4

NATIONAL HOME LIFE ASSURANCE COMPANY • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

DS43-771

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Reynolds L. Emerson, M.D.
 Medical Director



DRS. BIELEK, BIRELY, SALERNO P.A.

INTERNAL MEDICINE AND CARDIOLOGY
GASTROENTEROLOGY
837 N.E. 20TH AVENUE
FORT LAUDERDALE, FLORIDA 33304
PHONE 523-8514

Mrs. Betty Champion
412 S.E. 9 Court
City

NEW PHONE NUMBER
764-5514

ADDRESS

NAME

CHAMPION, BETTY, MRS. #4447

AGE

48

(bus, unimodal 824-0405)

PHONE

524-6446

DATE	PROFESSIONAL SERVICE	CHARGE	PAID	BALANCE
1/2/70	OC	10.00		10.00
1/10/70	OC	10.00		
	FBS	7.00		27.00
2/16/70	FBS	7.00		34.00
3/17/70	OC	10.00		
	FBS	7.00		51.00
3/17/70	n.y. life ins.	2.00		53.00
4/10/70	FBS	7.00		60.00
4-30	#2			
5/4/70	e/c		53.00	7.00
7-15-70	e/c		7.00	
1-12-71	n.y. life ins.	2.00		2.00
2/3/71	e/c		2.00	
2-15-71	OC	10.00		10.00
2-18-71	Admit Hosp.			
	1st day	35.00		
	7 days at 157	1095.00		
	21 " at 7.50	157.50		
3-17	Disch Hosp	797.50		3072.50

CODE:

PE - COMPLETE PHYSICAL
EKG - ELECTROCARDIOGRAM

IOC - FIRST VISIT
PAP - CANCER SMEAR

OC - OFFICE CALL
UC - "

NATIONAL HOME
HEALTH
PLAN.

320 

Dr. B. R. Birely
837 NE 20 Avenue
Ft. Lauderdale, FL

Date 05 10 72 3s 354
Patient's Name Elizabeth Champion
Address 412 SE 9th Ct.
Ft. Lauderdale, FL
File No. 5580623

Dear Doctor:

We would appreciate your assistance in processing our policyowner's request for benefits. The above named patient indicated that you treated him (or her) prior to a recent hospital confinement. Please answer the following:

1. When did the patient first experience symptoms of:

- a. ASHD February 1972
- b. Hypertension 1965
- c. Arteriosclerosis does not have, except # 1.

2. Which of the above conditions caused the patient's recent Congestive Heart failure? Arteriosclerotic heart disease.

3. In your opinion, approximately what percentage of or how many days of the patient's confinement may be attributed to the treatment of Obesity?

No way to seperate conditions.

Date 5-15-72

Signed 

This letter is being sent to you in duplicate so you will have a copy for your file. (Sign and date one copy before returning).

We do appreciate your assistance in this matter and a prepaid envelope is enclosed for your convenience. Should you request it, we would be willing to pay a reasonable clerical fee for the time involved.

Sincerely,



REW:rt
D480-971

R. E. Watters
Claim Department

DRS. BIELEK, BIRELY, SALERNO
PROFESSIONAL ASSOCIATION
INTERNAL MEDICINE
CARDIOLOGY - GASTROENTEROLOGY

837 N. E. 20TH AVENUE

523-8514

FORT LAUDERDALE, FLORIDA

NEW PHONE NUMBER
734-5514

April 17, 1972

5/1
JW

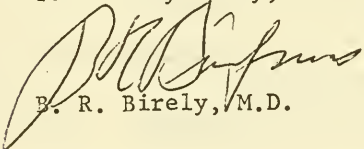
Mr. R. E. Watters,
Claim Services Division
National Home Life Assurance Company
Valley Forge, Pennsylvania 19481

Dear Mr. Watters:

re: Betty Champion

The aforementioned patient was admitted to Broward General Hospital on February 8, 1972 for obesity and congestive heart failure. The congestive heart failure was a new diagnosis - not pre-existing.

Yours very truly,



B. R. Birely, M.D.

DDD /mf

5580623
POLICY NUMBER
JUL 5/4/77

109 5/4 4
EXAMINER'S INITIALS, DATE & TIME

RECORD REQUEST

X	FORM NEEDED	RECORD REQUEST
	AUTHORIZATION	INFO
	CLM. FORM - PO	15 DL
	CLM. FORM - DR	SMR
	HOSPITAL BILL	HOSP. STATUS REG.
	TO WATS FOR FOLLOW-UP	SNAP OUT
	RETAIL CREDIT	FLEXO LETTER - 24 - 8

HOSPITAL X RECORDS	Broward 2/8	305-525-5411 5.00
-----------------------	----------------	----------------------

DOCTOR INFORMATION

R&S Dr. _____	
H & C ?S X Dr. <u>Birely</u> _____	HC 1a-c HC4 congestive heart failure R3 obesity
SPECIAL ?S Dr. _____	
RETURN FILE TO EXAMINER	

6/10 25 110
DATE RECORD REQUEST COMPLETED

National Home Life Assurance Company / Adm. Offices: Valley Forge, Pa. 19481

DATE OF DRAFT 05/11/72

ELIZABETH CHAMPAGNE
2100 S. BROADWAY AVE
ST. LOUIS, MO.
63106

NO. 223411-0

CHECK
AMOUNT \$44,000.00

NON-NEGOTIABLE

9024496

ELIZABETH CHAMPAGNE

412 S. BROADWAY
ST. LOUIS, MO.
63106

Date: 05/11/72
Policy No. 5000023
Entered Hospital: 02/06/72

Medical Record Librarian:

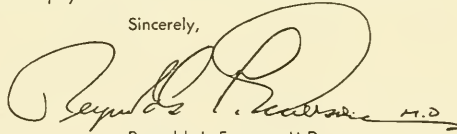
Would you please send us a copy of your records pertaining to the above named patient, who is awaiting disposition of a claim that has been filed with us.

The following information is necessary to the prompt handling of this claim: 1. Admission Sheet, 2. History of Present Illness, 3. Past Medical History Sheet and Physical Examination or Review of Systems, 4. Discharge Summary and 5. Dates and Diagnoses of Prior Admissions.

We appreciate your cooperation on behalf of your patient, our policy-owner. We have enclosed the patient's authorization, postpaid reply envelope as well as our bank draft to cover your services.

Your immediate attention will enable us to resolve your patient's claim more quickly, and of course, we will honor any appropriate assignment of benefits you might have on a payable claim.

Sincerely,



Reynolds L. Emerson M.D.
Medical Director

RLE/of
D755-671-5

Enclosures: Authorization
Return Envelope

SECOND REQUEST

FILE No. 5 61 5145

This subject is a 51 year old female confined in the hospital from November 1, 1970 to November 7, 1970, for cystocele, rectocele. The claim was rejected on the grounds of pre-existing conditions because the first symptoms were manifested in October 1970. This is interesting in that the patient indicates in a letter to the company that when she first purchased the policy, she advised the company that they might consider her condition was pre-existent; and if there was any doubt, she wanted her first payment check returned because she wanted nothing to do with a company who did business in this manner.

She indicates that she had never been fraudulent in any claim and only asked to have her check returned if there was any doubt. She goes on to say that her check was cashed after a thorough explanation about her condition before sending a claim application to the company. She further requests a refund of her entire payments since she had fully advised the company before making application.

The representatives of the company indicated that to their best they could determine this subject's policy payments were never refunded.

National Home Life Assurance Company

ADM. OFFICES:
VALLEY FORGE
PENNSYLVANIA
.....19481

January 13, 1971

Policy 5615145

Mrs. Marie L. Dohrman
141 North East 10th Avenue
Hallandale, Florida 33009

Dear Mrs. Dohrman:

We have completed our review of your request for benefits.

Medical reports received show your recent loss was due to a condition which started before your policy was issued and since pre-existing conditions are not yet covered, we can not approve benefits for this claim.

We regret that we are unable to write you more favorably at this time, but hope we can be of service in the future.

CLAIM DEPT. EC 2/6
2-6-13

Sincerely,

R. E. Watters

R. E. Watters
Claim Services Division

REW:dw

Jan. 18, 1971

Dear Mr. Watters,

When I sent the payment for the insurance I told your company that they might say that my condition was pre-existent and if there was any doubt, I wanted my check returned because I want nothing to do with a company who does business in this manner. We have never been fraudulent in any claim, and only asked to have my check returned if

Established 1920 - Over 50 Years of Service

National Home Life Assurance Company • Admin. Offices, Valley Forge, Pennsylvania 17881

cashed, and ^{crashed} after a thorough
 explanation about my condition before
 a claims application was sent
 to your company. Each symptom
 of my condition was entered even
 to seeing a doctor in September at
 Ocean City, Maryland. Your company
 can say that any condition was
 pre-existing before becoming ill.

Please refund as I asked before,
 my entire payment. I asked this
 before my premium was due, and
 will expect it on the return mail.
 If I hadn't requested this in November,
 I would feel differently about it at
 this time. Thank you for your attention

Sincerely,
 Thane L. Doherty

P.S.

I'm sure that my
 letter must be on file.

NAME AND ADDRESS OF PATIENT Mrs Marie L. Pohnmann 0		5615145		12	09	70	H 046172
FORM LETTERS TO BE SENT		POLICY NUMBER		DATE NOTIFIED		CLAIM NO.	
SMR		DATE OF LOSS		SEP	AGE	TYPE	
BE 3 (f)		11 1 70		F	51	Wp	5
BE 5 (m) to		MO. DAY YR.				CODE SYMBOLS	
ANC to							
		FOLLOW UP		ADJUSTOR		WANTED	
						Auth. Needed	
						Claim Form P.D. Side	
						Claim Form DR Side	
						Hospital Records	
						Hospital Bill	
						Staff Letter	
						15 DL Letter	
						Retail Credit	
						See Instructions	

SPECIAL INSTRUCTIONS:

First Symptom in Aug. D.O.I. 11/14/70

- 10 ☐ PAY
 11 ☐ PAY - WAV. BEFORE PAY
 12 ☐ PAY - WAV. AFTER DEC.
 21 ☐ REJ. - NO CONFINEMENT
 22 ☐ REJ. - POLICY Lapse
 23 ☐ REJ. - NOT INSURED/COVER
 24 ☒ REJ. - PRE EXISTING
 25 ☐ REJ. - WAVERED
 30 ☐ RESCIND
 40 ☒ ABANDON
 50 ☐ DUPLICATE
 60 ☐
☐ LE
☐ NON-LE

NATIONAL HOME LIFE ASSURANCE CO.

CLOSING

DIAGNOSTIC CODE	MO. DAY YR.	<input type="checkbox"/> YES	<input type="checkbox"/> PARTIAL	NO. DAY YR.	CRAFT NO.	CRAFT DATE	TOTAL AMOUNT
6	12/17/70	<input checked="" type="checkbox"/> NO	<input type="checkbox"/> COMPLETE				
	DATE CLOSED	WAIVER ADDED	<input type="checkbox"/> ADD'L				

BASE

Hosp. Days at / \$
 Conv. Days at /
 Dr. visits at /
 Nurse visits at /
 Days Dis. Inc. at /

Surgery

Dismemberment

Accidental Death

RIDER

TYPE

Hosp. Days at /
 Conv. Days at /
 Dr. visits at /
 Nurse visits at /
 Days Dis. Inc. at /

Surgery

Dismemberment

Accidental Death

TOTAL

01 ☐ PAYEE AS ABOVE

02

03 ☐ OTHER

04

05 NAME AND ADDRESS

06

07

08

09

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

National Home Life Assurance Company

VALLEY FORGE
PENNSYLVANIA
..... 19481

129

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.

Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.

After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner MRS. MARIE DOHRMAN
 Patient MARIE DOHRMAN
 Telephone 925-7636 Age 51

POLICY NUMBER(S)	
<u>5615145</u>	<u>P 3</u>

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:
Cystitis & Cystocele
urethraeals was the reason for my visit to Dr
MARY FRANK. I was working w. North during the summer when this first
2. Date of first symptoms: August 3. Date first treated: Aug. 31, 1970
4. Give names and addresses of all physicians who have treated patient during illness or accident:
DR. MARY FRANK
Beach Hwy. Ocean City, Md. 21542
DR. Sidney Peck 1111 N. Hollywood Blvd., Hollywood, Fla.
5. Name of hospital Hollywood Memorial
 Address Johnson St. Hollywood, Fla.
6. Dates hospitalized: From Aug 1, 1970 To Nov 1, 1970
7. Has this disease caused previous trouble? information none If so, when?
 Treated by: Dr. Frank Townsend
8. Name of patient's family doctor Dr. Frank Townsend
 Address of family doctor 1111 N. Hollywood Blvd., Ocean City, Md. 21542 How long? 12 yrs

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated 100 27 19 70 CLAIMANT SIGN HERE Mrs. Marie Dohrman

Claimant's Address 1111 N. Hollywood Blvd. City Hollywood State Fla Zip Code 330

Approved by: X _____ Degree _____

ATTENDING PHYSICIAN

PHYSICIAN: PLEASE SIGN TWICE

(1) "Patient's Authorization" on reverse side

(2) At bottom of this form

Patient's Name Marie Dohrman (Mrs. Henry) Age 51

1. Primary Diagnosis(es) Cystocele, rectocele
 Secondary Diagnosis(es) _____
 Complications, if any: _____

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? 11/2/70

3. When did patient first have medical attention for this condition? 11/2/70
 By whom? Dr. Sidney J. Peck, M. D.

4. Has patient ever had same or similar conditions ☐ YES ☒ NO
 If so, give date and describe _____

5. How long have you been patient's family doctor? A year

6. Was patient referred by another doctor? No
 Referring doctor's name and address _____

7. Name of hospital Memorial Hospital
 Address 3333 N. 35th Avenue, Hollywood, Florida 33021
 Dates confined: From 11/1/70 Admission To Discharge 11/8/70

8. Nature and charge for surgical procedure Anterior and posterior wall repair,
urethral plication \$ 350.00
 Place performed Memorial Hospital Date performed 11/2/70
 charge per call \$ \$25.00

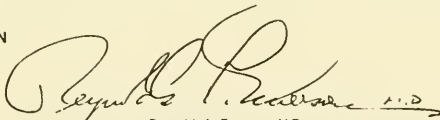
9. Dates of medical treatment by you:

OFFICE	HOME	HOSPITAL
<u>10/20/70</u>		

Date 12/4/70 SIGNED *Sidney J. Peck M.D.* M.D.
 Telephone 983-2100 Address 1111 N. 35th Avenue,
 City Hollywood State Florida Zip Code 33021

NATIONAL HOME LIFE ASSURANCE COMPANY • CFH170 • VALLEY FORGE, PENNSYLVANIA 19481

THANK YOU FOR YOUR COOPERATION



 Reynolds L. Emerson, M.D.
 Medical Director

STATEMENT
MEMORIAL HOSPITAL

3501 Johnson Street

HOLLYWOOD, FLORIDA 33021

PHONE: 987-2000

BLUE CROSS CODE NO. 233

MEDICARE PROVIDER NO. 10-0035

PAGE NO. 1

PATIENT : DOHRMAN MARIE2

BILL TO : HENRY DOHRMAN
141 NW 10 AVE
APT 17D
MALLANDALE FLA

ADMITTING DATE	DISCHARGE DATE
11/01/70	11/08/70
BILLING DATE	
11/11/70	

HOSPITAL NO	PATIENT NO.	MEDICAL RECORDS NO
11	813490	

DATE		DESCRIPTION	INS. CODE	CHARGES	COVERED CHARGES	PAYMENTS AND CREDITS	ESTIMATED DUE FROM PATIENT
MONTH	DAY						
		ROOM TA RATE DAYS CHARGE					
		4247 SP 25.00 7 175.00					
		TOTALS 7	1	17500			
		OPER AND RECOV ROOMS	2	9500			
		ANESTHESIA-OR	5	2300			
		LABORATORY	6	1300			
		PATHOLOGY	7	1200			
		DRUGS	10	4510			
		C9R	13	3300			
		TRANSFUSION SET UP	20	750			
		REC-PATIENT				5000	
		INS1 377 2 1100024			36905		
TOTALS →				40360	36905	5000	15455

NOT FOR INSURANCE PURPOSES

NOTICE TO PATIENT: PLEASE PAY LAST AMOUNT IN THIS COLUMN

STATUS REPORT

DEPT #	EMP #	POLICY #	ID	DATE	REF CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESQ QUOTE
1524	0092	5615145	DOH	17/10/70	4			.00	.00
DUE DATE								NAME	
71/05/14								MRS MARIE L DOHRMAN	
EFFECTIVE DATE								ADDRESS	
70/10/14								APT 178 141 NE 10TH AVE	
CASH								HALLANDALE	
DATE LAST TRANS								FLA 33009	
70/11/3									
PUBLICATION CODE									
141-0686-3-2									
DATE NEXT EXTRACT									
70/12/14									
TEST CODE									
48.31									
MONTHLY									
4.15									
QUARTERLY									
11.82									
SEMI ANNUAL									
22.41									
ANNUAL									
41.50									
DATE LAST CLAIM PAID									
CLAIM PAID									
AMOUNT PAID FOR CLAIM									
PREMIUM ADJUSTMENT									
DATE FOR PREM ADJUST									
MULTI-POLICY									
WAIVERS									
DEPENDENTS AND OTHER TRAILERS									
NO	TYPE	NAME				BIRTH DATE	EFF DATE	AGE	RATE
1	P3	HENRY J DOHRMAN				07/03/	70/10/	63	00
OTHER TRAILERS									
R	8.90	25.35	48.06	89.00					
Z01	701214	FG	701114	3.00	8.55	16.20	30.00	3.00	701214
DATE	TRAN	DOCU	AMOUNT	FROM	TO	U DATE	U TR	U DOC	
1014	84		0.25	701014	701114				
1119	85	5461	48.06	701114	710514				
1118	09	5461		29P300890025350480508900					

Effective Date of Change

Check Payable to

YR	MO	DA	Transaction Code	Location	Reference No.	Check Payable to	Check Route
13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28
29	30	31	32	33	34	35	36
37	38	39	40	41	42	43	44
45	46	47	48	49	50	51	52
53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68
69	70	71	72	73	74	75	76
77	78	79	80	81	82	83	84
85	86	87	88	89	90	91	92
93	94	95	96	97	98	99	00

Field A - New Field NOTE "@" sign must follow last character on transaction #1 only

31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Field B - Old Field NOTE "@" sign must follow last character on transaction #1 only

56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Explanation _____ Approved by _____

FILE NO. 5 61 4976

This subject is a 38 year old female with 8 children. The subject was admitted to the hospital on March 7, 1971 and stayed until March 18, 1971 in connection with an intra-uterine fetal death.

The subject's four year old son was confined in the hospital from March 24 to March 26, 1971 for a tonsillectomy with adenoidectomy.

The company rejected both claims; the mother's claim on the grounds of policy lapse and the son's claim on the grounds of *pre-existing conditions, since the doctor reported that the boy had had recurrent sore throats most of his life*. An additional ground for the boy's rejection was policy lapse.

From the files it would appear that the policy had been paid on a regular basis since its inception in October 1970. Apparently for some reason the 1970 December payment was not received until February of 1971 although the payment for January had apparently been received and recorded by the company.

The subject in a letter to the company indicated that she was not notified of any policy lapse; and as of July 1971 was continuing to pay on the policy, and these premiums were continuing to be accepted by the company.

The question is raised as to whether or not the acceptance of the December payment even though late would not constitute a waiver of the company's right to claim lapse.

pk

NAME OF PATIENT
Mrs Flora M Thomas

O 5614976

06 28 71

H 123469

POLICY NUMBER

DATE NOTIFIED

CLAIM NO.

DATE OF LOSS

SEA AGE TYPE

2-16-71

P 38 WP4

S

MO DAY YR

CODE SYMBOLS

FOLLOW UP

ADJUSTOR

WANTED

FORM LETTERS TO BE SENT:

SMR

BE 3 (f)

BE 5 (m) to

ANC to

Auth. Needed

Claim Form P.O. Side

Claim Form DR Side

Hospital Records

Hospital Bill

Info Letter

15 DL Letter

Retail Credit

See Instructions

SPECIAL INSTRUCTIONS:

10 ☐ PAY11 ☐ PAY - WAV. BEFORE PAY12 ☐ PAY - WAV. AFTER DEC21 ☐ REJ - NO CONFINEMENT22 ☒ REJ - POLICY LAPSE23 ☐ REJ - NOT INSURED/COVER24 ☐ REJ - PRE EXISTING25 ☐ REJ - WAVED30 ☐ RESCIND40 ☐ ABANDON50 ☐ DUPLICATE60 ☐

2/16-2/28

3/7-3/18

NATIONAL HOME LIFE ASSURANCE CO.

CLOSING

6	MO	DAY	YR.	<input type="checkbox"/> YES	<input type="checkbox"/> PARTIAL	MO	DAY	YR.
DIAGNOSTIC CODE	DATE CLOSED	<input checked="" type="checkbox"/> NO	<input checked="" type="checkbox"/> COMPLETE	WAIVER ADDED	ADD'L	DRAFT NO.	DRAFT DATE	TOTAL AMOUNT

BASE

Hosp. Days at /

Conv. Days at /

Dr. visits at /

Nurse visits at /

Days Dis. Inc. at /

Surgery

Disembodiment

Accidental Death

KIDER

TYPE

Hosp. Days at /

Conv. Days at /

Dr. visits at /

Nurse visits at /

Days Dis. Inc. at /

Surgery

Disembodiment

Accidental Death

TOTAL

01 ☐ PAYEE AS ABOVE02 ☐ OTHER

03 NAME AND ADDRESS

04 First printed 2/8/71

05 premium due 12/16/70

06 not paid until 2/4/71

07

08

09

10

Adjustor No.

235

National Home Life Assurance Company

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

- ① Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.
- ② Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.
- ③ After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner Florence M. Thomas
Patient Florence M. Thomas
Telephone 3420338 Age 38

POLICY NUMBER(S)

5614976

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

2. Date of first symptoms: October 3. Date first treated: _____

4. Give names and addresses of all physicians who have treated patient during illness or accident:

5. Name of hospital North Detroit General Hospital

Address 3105 Carpenter Detroit Mich. 48212

6. Dates hospitalized: From Feb. 16 - 1971 To Feb. 28 - 1971

7. Has this disease caused previous trouble? _____ If so, when? _____

Treated by: _____

8. Name of patient's family doctor Dr. Charles May

Address of family doctor 18984 Lenoir

How long? _____

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
AOM OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated 4-13 19 71 CLAIMANT SIGN HERE Florence M. Thomas

Claimant's Address 16212 Monica City Detroit State Michigan Zip Code 48221

Approved by: X _____ Degree _____

ATTENDING PHYSICIAN

PHYSICIAN: PLEASE SIGN

IN THE FOLLOWING PLACES AS INDICATED

- (1) "Patient's Authorization" on reverse side
 (2) At bottom of this form above the perforation

Patient's Name FLOREN THOMAS Age 38

1. Primary Diagnosis(es) Intra uterine fetal death
 Secondary Diagnosis(es) none
 Complications, if any: none

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? October

3. When did patient first have medical attention for this condition? Feb. 6, 1971
 By whom? CARLOS MAX M.D.

4. Has patient ever had same or similar conditions ☐ YES ☒ NO
 If so, give date and describe _____

5. How long have you been patient's family doctor? 4 months

6. Was patient referred by another doctor? no
 Referring doctor's name and address _____

7. Name of hospital North Detroit General Hospital
 Address 3105 Carpenter Avenue
 Dates confined: From Feb 16, 1971 To Feb 28, 1971

8. Nature and charge for surgical procedure _____
 \$ _____

Place performed _____ Date performed _____

9. Dates of medical treatment by you: _____ charge per call \$ _____

OFFICE 2/6/71, 2/11/71, 2/25/71 HOME _____ HOSPITAL 2/11/71 - 2/21/71

Date June 17, 1971 SIGNED [Signature] M.D.

Telephone 864-9292 CARLOS MAX, M.D. Tax Identification Number _____
 18984 LIVERNOIS Address 18984 Livernois
 City Detroit State Michigan Zip Code 48221

NATIONAL HOME LIFE ASSURANCE COMPANY • FH1007 • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Reynolds L. Emerson, M.D.
 Medical Director



National Home Life Assurance Company

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

- ① Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.
- ② Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.
- ③ After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner Irene M. Thomas
Patient Irene M. Thomas
Telephone 3420338 Age 38

POLICY NUMBER(S)

5614976

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

2. Date of first symptoms: October 3. Date first treated: _____

4. Give names and addresses of all physicians who have treated patient during illness or accident:

5. Name of hospital North Detroit General Hospital
Address 3105 Carpenter Detroit Mich. 48212

6. Dates hospitalized: From March 7-1971 To March 18-1971

7. Has this disease caused previous trouble? _____ If so, when? _____

Treated by: _____

8. Name of patient's family doctor Dr. Charles M. J. J.

Address of family doctor 18784 Lincoln How long? _____

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated 4-13 19 71 CLAIMANT SIGN HERE Irene M. Thomas

Claimant's Address 16212 Monica City Detroit State Michigan Zip Code 48221

Approved by: _____ Degree _____

ATTENDING PHYSICIAN

PHYSICIAN: PLEASE SIGN

IN THE FOLLOWING PLACES AS INDICATED

- (1) "Patient's Authorization" on reverse side
 (2) At bottom of this form above the perforation

Patient's Name Elora Thomas Age 38

1. Primary Diagnosis(es) Intra uterine Fetal death
 Secondary Diagnosis(es) Same
 Complications, if any: none

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? October

3. When did patient first have medical attention for this condition? Feb. 8, 1971
 By whom? CARLOS MAX M.D.

4. Has patient ever had same or similar conditions ☐ YES ☒ NO
 If so, give date and describe _____

5. How long have you been patient's family doctor? 4 months

6. Was patient referred by another doctor? no
 Referring doctor's name and address _____

7. Name of hospital North Detroit General Hospital
 Address 3105 Carpenter Avenue
 Dates confined: From 3/12/71 To 3/18/71

8. Nature and charge for surgical procedure Supra cervical hysterectomy
 \$ _____

Place performed North Detroit General Hosp. Date performed 3/13/71
 charge per call \$ _____

9. Dates of medical treatment by you:

OFFICE	HOME	HOSPITAL
<u>3/20/71, 3/22/71, 3/27/71</u>	<u>CARLOS MAX, M.D.</u>	<u>3/17/71 - 3/18/71</u>

Date June 17, 1971 SIGNED CARLOS MAX, M.D. M.D.
 Telephone 8649292 Address 18284 LIVERMORE
DET., MICH. 48221
 City _____ State _____ Zip Code _____

NATIONAL HOME LIFE ASSURANCE COMPANY • CFH082 • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Reynolds L. Emerson, M.D.
 Medical Director



STATUS REPORT

DEPT #	EMP #	POLICY #	ID	DATE	PIC CODE	CLAIM REASON	CLAIM #		
1626	0039	5614976	THO	06/28/71	4				
DATE	MODE	EFFECTIVE DATE	OCF	PRE BILL	LAST PNL	TYPE	SEX	BIRTH DATE	AGE
71/09/04	4	70/10/16	9	000		WP4	F	32/07/22	38
DATE LAST TRANS	CASH	OTHER	PUBLICATION CODE	IFL	MI STAT	LAPSE	PRV LAPSE		
71/06/11	71/05/21	5-0686-6-54					2		
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	SEMI ANNUAL	ANNUAL	ST C	M
71/08/17		103.06	00	3.30	9.40	17.82	33.0021		
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	MULTI POLICY				
71/05/05	1	0.00							
WAIVERS									

DEPENDENTS AND OTHER TRAILERS

NO	TYPE	NAME	BIRTH DATE	EFF DATE	AGE	DATE 1	MO	QUAR	SEMI	ANN	ANN
1	P4	DARLITA L THOMAS	70/03/	70/10	0000	F000000000000000000000					
2	P4	GEORGE BENNETT	07 07	70 10	6300	M00475013530256504750					
3	P4	GEORGENA R BENNETT	64 07	70 10	0600	F000000000000000000000					
4	P4	NADRA L BENNETT	66 06	70 10	0400	F000000000000000000000					
5	P4	IRENE E THOMAS	55 02	70 10	1500	F000000000000000000000					
6	P4	LEWYNN E THOMAS	56 04	70 10	1400	M000000000000000000000					
7	P4	ARQUITA V THOMAS	50 03	70 10	2000	F00330009400178203300					
8	P4	HUBERT E THOMAS	52 04	70 10	1800	M000000000000000000000					

OTHER TRAILERS

F 1.75 4.98 9.45 17.50
R 13.10 37.31 70.74 131.00

DATE	TRAN	DOCU	AMOUNT	FROM	TO	U DATE	U TR	U DOC
0118	23			R				
0204	67			701216	710204			
0204	85	2246	26.20	710204	710404			
0426	85	2234	13.10	710404	710504			
0426	85	5010	13.10	710504	710604			
0428	17	0001		G				
0505	60	CY28	0.00			710505		
0607	85	2223	37.31	710604	710904			
0607	09	2223		49P401310037310707	413100			

Effective Date of Change

Check Payable to

YR	MO	DA			
13	14	15	16	17	18

Transaction Code

Location

Reference No.

NIL

Check Route

Main Insured

Estate of MI

Field A - New Field NOTE "@" sign must follow last character on transaction #1 only

31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Field B - Old Field NOTE "@" sign must follow last character on transaction #1 only

56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Explanation

Approved by

Prepared by

Date

NAME OF PATIENT Madra L. Bennett 04		POLICY NUMBER 5614976		04	28	71	CLAIM NO H096069
		DATE OF LOSS 03 24 71		SEX F	AGE 4	TYPE SP4		CODE SYMBOLS S
FOLLOW UP		ADJUSTOR		WANTED			
				Auth. Needed			
				Claim Form P.O. Side			
				Claim Form DR Side			
				Hospital Records			
				Hospital Bill			
				Info Letter			
				15 DL Letter			
				Retail Credit			
				See Instructions			

SPECIAL INSTRUCTIONS:		10 <input type="checkbox"/> PAY
<i>also policy typed</i>		11 <input type="checkbox"/> PAY - WAF. BEFORE PAY
		12 <input type="checkbox"/> PAY - WAF. AFTER DEC.
		21 <input type="checkbox"/> REJ. - NO CONFINEMENT
		22 <input type="checkbox"/> REJ. - POLICY LAPSE
		23 <input type="checkbox"/> REJ. - NOT INSURED/COVER
		24 <input checked="" type="checkbox"/> REJ. - PRE EXISTING
		25 <input type="checkbox"/> REJ. - COVERED
		26 <input type="checkbox"/> RESCIND
		40 <input type="checkbox"/> ABANDON
		50 <input type="checkbox"/> DUPLICATE
60 <input type="checkbox"/>		

NATIONAL HOME LIFE ASSURANCE CO.		CLOSING	
4	MO. DAY YR. 5 15 71	YES <input type="checkbox"/> PARTIAL <input checked="" type="checkbox"/> COMPLETE <input type="checkbox"/> NO WAIVER <input type="checkbox"/> ADD'L <input type="checkbox"/>	MO. DAY YR. DATE CLOS'D
DRAFT NO.	DRAFT DATE	TOTAL AMOUNT	

BASE		01 <input type="checkbox"/> PAYEE AS ABOVE
Hosp. Days at _____ / _____ \$ _____		02
Conv. Days at _____ / _____		03
Dr. visits at _____ / _____		04 <input type="checkbox"/> OTHER
Nurse visits at _____ / _____		05 NAME AND ADDRESS
Days Dis. Inc. at _____ / _____		06
Surgery _____		07
Dismemberment _____		08
Accidental Death _____		_____
RIDER		_____
TYPE		_____
Hosp. Days at _____ / _____		31
Conv. Days at _____ / _____		32
Dr. visits at _____ / _____		33
Nurse visits at _____ / _____		34
Days Dis. Inc. at _____ / _____		35
Surgery _____		36
Dismemberment _____		37
Accidental Death _____		38
TOTAL _____		Adjuster No. 195

National Home Life Assurance Company

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

1. Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.
2. Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.
3. After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner Flora M. Thomas

Patient Nadine L. Bennett

Telephone 3420.338 Age 4 yrs.

POLICY NUMBER(S)

5614976

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

Tonsillotomy

2. Date of first symptoms: _____ 3. Date first treated: _____

4. Give names and addresses of all physicians who have treated patient during illness or accident:

Dr. Maria J. Morris - 12632 Keston Detroit, Mich 48238
Dr. Douglas A. Strong - 5050 Gay Road Suite 106 Detroit, Mich 48204
Dr. B. Phillips " " " "

5. Name of hospital The Home Hospital

Address Detroit, Mich 48201

6. Dates hospitalized: From 3-24-71 To 3-26-71

7. Has this disease caused previous trouble? yes If so, when? for the last several months

Treated by: Dr. Morris

8. Name of patient's family doctor _____

Address of family doctor _____ How long? _____

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated 4-2 19 71 CLAIMANT SIGN HERE: Flora M. Thomas

Claimant's Address 16212 Manica City Detroit State Mich. Zip Code 48221

Approved by: _____ Degree _____

ATTENDING PHYSICIAN

PHYSICIAN: PLEASE SIGN
IN THE FOLLOWING PLACES AS INDICATED

- (1) "Patient's Authorization" on reverse side
(2) At bottom of this form above the perforation

Patient's Name Nadra Bennett Age 4

1. Primary Diagnosis(es) Recurrent sore throats
Secondary Diagnosis(es) _____
Complications, if any: _____

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? Most of life

3. When did patient first have medical attention for this condition? 1970
By whom? M.J. Morris, M.D.

4. Has patient ever had same or similar conditions ☐ YES ☒ NO
If so, give date and describe _____

5. How long have you been patient's family doctor? 3/8/71
Yes

6. Was patient referred by another doctor? _____
Referring doctor's name and address M.J. Morris, M.D. 12632 Dexter Detroit, Michigan

7. Name of hospital Grace Hospital
Address 4100 John R. Detroit, Michigan
Dates confined: From 3/24/71 To 3/26/71

8. Nature and charge for surgical procedure Tonsillectomy with Adenoidectomy
\$ 150.00
Place performed Grace Hospital Date performed 3/25/71

9. Dates of medical treatment by you: _____ charge per call \$ 17.00 & 10.00

OFFICE	HOME	HOSPITAL
<u>3/8/71; 4/6/71</u>		

Date 4/9/71 SIGNED Douglas A. String M.D.
Tax Identification Number _____
Telephone To-46166 Address 5050 Joy Rd.
City Detroit State Michigan Zip Code 48204

NATIONAL HOME LIFE ASSURANCE COMPANY • FH1007 • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Reynolds L. Emerson, M.D.
Medical Director



Effective Date of ChangeCheck Payable to:

YR						MO				DA		Transaction Code				Location				Reference No				NLL		Check Route			
13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30												

Field A - New Field NOTE "@" sign must follow last character on transaction #1 only

[illegible]

Field 8 - Old Field NOTE "@" sign must follow last character on transaction #1 only

56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

Exploration

Approved by

Prepared by

date

STATUS:

CLAIM REJECTED DUE TO
POLICY LAPSEIF THE CLAIM SHOULD BE
REVIEWED, RETURN TO
337 - CLAIMS CLERICALIF YOU AGREE, BACK US
IN YOUR LETTER.

DEPT #	UNIT #	POLICY #	ID	DATE	REF #
1626	0039	5614976	IHO	06/28/71	4
DUE DATE	MODE	EFFECTIVE DATE	CLP	PRE BILL	TYPE
71/09/04	4	70/10/16	9	000	WP4
DATE LAST TRANS	OTHER	PUBLICATION CODE			
71/06/11	71/05/21	5-0686-6-54			
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY
71/08/17		103.06	00	3.30	9.40
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	
71/05/05	1	0.00			
WAIVERS					

DEPENDENTS AND OTHER TRAILERS

NO	TYPE	NAME	BIRTH DATE	EF DATE	AGE DATE	SEX	DOB	SSN	DOB
1	P4	DARLITA L THOMAS	03/03/70	10/10/70	0000F001		000000000000000000		
2	P4	GEORGE BENNETT	07/07/70	10/10/70	6300M001		75013530256504750		
3	P4	GEORGENA R BENNETT	04/07/70	10/10/70	0000F001		000000000000000000		
4	P4	NADRA L BENNETT	06/06/70	10/10/70	0000F001		000000000000000000		
5	P4	IRENE E THOMAS	02/02/70	10/10/70	0000F001		000000000000000000		
6	P4	LEWYNN E THOMAS	04/04/70	10/10/70	0000F001		000000000000000000		
7	P4	ARQUITA V THOMAS	03/03/70	10/10/70	2000F001		0009400178203300		
8	P4	HUBERT E THOMAS	04/04/70	10/10/70	1800M000		000000000000000000		

OTHER TRAILERS

F 1.75 4.98 9.45 17.50
R 13.10 37.31 70.74 131.00

DATE	TRAN	DOCU	AMOUNT	FROM	TO	U DATE	U TR	U DOC
0118	23			R				
0204	67			701216	710204			
0204	85	2246	26.20	710204	710404			
0426	85	2234	13.10	710404	710504			
0426	85	5010	13.10	710504	710604			
0428	17	0001		G				
0505	60	CY28	0.00			710505		
0607	85	2223	37.31	710604	710904			
0607	09	2223		49P401310037310707	413100			

Effective Date of Change

Check Payable to:

YR	MO	DA	Transaction Code	Location	Reference No	Check Route
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31	32	33

☐ NIL
☐ Main Insured
☐ Estate of MI

Field A - New Field NOTE: "@" sign must follow last character on transaction #1 only

31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Field B - Old Field NOTE: "@" sign must follow last character on transaction #1 only

56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Explanation

Approved by

July 21, 1971

Gentlemen;

I am writing you in regards to your previous letter about my two claims, one for my baby and the other for me. You say that my policy had lapsed, I do not see how that could be, I sent in my payments each month with the exception of the last six months & I paid them in three months each time. You said that you recieved my Dec. payment in Feb, I had sent the Dec, payment in Dec,. I do not see why you did not get it until Feb, and if the policy was lapsed why wasn't I notified & in other words you did recieve my Jan. payment but not Dec. Well I was not notified about any lapses that is why I continued to pay for the policy. I would appreciate it very much if you would recheck & see if the policy was lapsed why wasn't I notified. Why was the Jan. payment accepted & not the Dec? What was the past date on the envelope? Please check this out.

Thank you;

Mrs Flora Thomas

FILE NO. 5 59 2773

This subject was a 69 year old female who was treated in the physician's office for a contusion of the right arm occasioned by a car accident. The claim was rejected on the basis that there had been no hospital confinement. This would indicate that at least this subject apparently did not understand the terms of the contract providing that the coverage is in effect only when hospitalized.

STATUS WORKSHEET

DEPT #	EMP #	POLICY #	IO	DATE	REG CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESC QUOTE
1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13
DUE DATE	MODE	EFFECTIVE DATE	DCP	PRE BILL	LAST BILL	TYPE	SEX	BIRTH DATE	AGE
1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13
SPEC REL HAND CODE	CASH	DATE LAST TRANS	PUBLICATION CODE	IF1	MA	LAPSE	PREV LAPSE	NAME	
1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	RATES	SEMI ANNUAL	ANNUAL	ST M C
1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	MULTI-POLICY				
1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13				
WAIVERS									
DEPENDENTS AND OTHER TRANSERS									
NO	TYPE	NAME	BIRTH DATE	EFF DATE	AGE	RATES	MO	QUAR	RATES
1	1	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13	1-11-13
<p>RATES: 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13</p> <p>OFFER: 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13</p> <p>PREMIUMS TRANS-DAT: 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13 1-11-13</p>									

DECISION CODE

10	PAY	1	POLICY NUMBER	DATE NOTIFIED	CLAIM NUMBER
20	REJECT - NOT INSURED	6 7	13 14	19 20	21
21	REJECT - NO CONFINEMENT/SURGERY	SEX	AGE	DATE OF LOSS	POLICY TYPE
22	REJECT - LAPSE DUE PAID	26	27 28	29	34 35
23	REJECT - NOT COVERED (CODE)	DECISION CODE	DIAGNOSTIC CODE	DATE CLOSED	ADJUSTER NO
24	REJECT - PRE EXISTING	41	42 43	44	51 52
25	REJECT - WAIVER	VOID	PATIENT NAME (See above)	ID CODE	53
30	RESCIND	PARTIAL	COMPLETE	ADJL	54
40	ABANDON	55	56	57	58
50	DUPLICATE	59	60	61	62
60	OTHER	63	64	65	66

1	DAYS	RATE	TIME	AMOUNT	CODE
HOS DAYS					01
CONV DAYS					02
DR VISIT					03
NR VISIT					04
DAYS DIS					05
SUR					06
DIS MEM					07
A.D.					08
209					78
215					19
HOS DAYS					31
CONV DAYS					32
DR VISIT					33
NR VISIT					34
DAYS DIS					35
SUR					36
DIS MEM					37
A.D.					38
209					155
215					39
DRAFT #1 AMOUNT					179
					SSAN, OR TAX ID. NO.
					189
2	DAYS	RATE	TIME	AMOUNT	CODE
HOS DAYS					01
CONV DAYS					02
DR VISIT					03
NR VISIT					04
DAYS DIS					05
SUR					06
DIS MEM					07
A.D.					08
209					78
215					19
HOS DAYS					31
CONV DAYS					32
DR VISIT					33
NR VISIT					34
DAYS DIS					35
SUR					36
DIS MEM					37
A.D.					38
209					155
215					39
DRAFT #2 AMOUNT					179
					SSAN, OR TAX ID. NO.
					189
REASON #1 (90-106)		REASON #2 (107-123)		REASON #3 (124-140)	REASON #4 (141-174)
RETURN CHECK(S) TO		BE(S) TO		SMR	
		ANC TO		BE3(I)	
					DRAFT SUMMARY
					DRAFT #1 \$
					DRAFT #2 \$
					DRAFT #3 \$
					TOTAL AMOUNT THIS CLAIM \$

BENEFITS FOLDER

National Home Life Assurance Company

A FEB 15 1972 - 1 52 AM

VALLEY FORGE
PENNSYLVANIA
..... 19481

HOW TO MAKE A CLAIM . . . SIMPLY AND QUICKLY

We'll give your claim immediate attention when we receive this form. Just follow these easy instructions:

Fill in this form—completely and accurately—as soon as you or a covered member of your family has a loss under the policy. Be sure to sign your name at the bottom of this form. Also please send available bills.

Give the form to your physician. Ask him to sign the "Patient's Authorization", and to complete the reverse side.

After both you and your physician have completed and signed the form, mail it directly to National Home. You don't have to employ anyone or see an agent to claim your benefits.

Policyowner

Esther Richardson

Patient

yes

Telephone

Age 49

POLICY NUMBER(S)

2701937

5592773

1. Give full description of injury or illness from which patient suffered. If injury, tell when, where and how it happened:

car collision, which other car in fault
I was knocked to floor, my right arm hit
dark board, & bruised it, terrible, which I feel.

2. Date of first symptoms:

Jan 5-1972

3. Date first treated:

Jan 6-72

4. Give names and addresses of all physicians who have treated patient during illness or accident:

W. E. Jones, M. D.

Dr. also had a \$10.00 dollar drug bill to pay.

5. Name of hospital

Address

6. Dates hospitalized: From

To

7. Has this disease caused previous trouble?

If so, when?

Treated by:

8. Name of patient's family doctor

W. E. Jones

Address of family doctor

Box 110 Britton

How long?

21st time

AUTHORIZATION FOR PATIENT'S RECORD

TO NATIONAL HOME LIFE ASSURANCE COMPANY
AOM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

I do hereby authorize any physician, or any other person who has ever attended me, or any hospital in which I may have ever been treated, to disclose any knowledge or information which was acquired.

Dated

19

CLAIMANT SIGN HERE

Esther Richardson

Claimant's Address

City

Britton

State

Oklahoma

Zip Code

74010

Approved by:

Degree

ATTENDING PHYSICIAN

PHYSICIAN: PLEASE SIGN
IN THE FOLLOWING PLACES AS INDICATED

- (1) "Patient's Authorization" on reverse side
(2) At bottom of this form above the perforation

Patient's Name Esther Richardson Age 69

1. Primary Diagnosis(es) Contusion, right arm.

Secondary Diagnosis(es) _____

Complications, if any: _____

2. If injury, when and how did it occur? If sickness, when did first symptoms appear? _____

Car accident, 1-5-72

3. When did patient first have medical attention for this condition? 1-6-72

By whom? W. E. Jones, M. D.

4. Has patient ever had same or similar conditions ☐ YES ☐ NO

If so, give date and describe _____

5. How long have you been patient's family doctor? This is the first time I have treated this patient.

6. Was patient referred by another doctor? _____

Referring doctor's name and address _____

7. Name of hospital _____

Address _____

Dates confined: From _____ To _____

8. Nature and charge for surgical procedure _____

\$ _____

Place performed _____ Date performed _____

9. Dates of medical treatment by you: _____ charge per call \$ _____

OFFICE
See itemized statement

HOME

HOSPITAL

Date 2-8-72 SIGNED W. E. Jones M.D.

Tax Identification Number 73-0665212

Telephone 367-2202 Address Box 1110

City Bristow State Okl. Zip Code 74010

NATIONAL HOME LIFE ASSURANCE COMPANY • ADM. OFFICES: VALLEY FORGE, PENNSYLVANIA 19481

D541-771

Thank you for providing the medical information necessary so we may more quickly resolve your patient's claim that has been filed with us.

We appreciate your cooperation on behalf of your patient, our policyowner.

Sincerely,

Reynolds L. Emerson, M.D.
Medical Director



STATEMENT

W. E. JONES, JR., M.D.
 408 WEST FOURTH STREET P.O. BOX 1110, BRISTOW, OKLAHOMA
 TELEPHONE 7MERSON 7-2201

Esther Richardson
 623 E. 5th
 Bristow, Okla. 74010

CHARGES DUE 10TH EACH MONTH

DATE	BY	PATIENT	CHARGES	PAYMENTS	PAY LAST AMOUNT IN THIS COLUMN BALANCE
IAN 5 72OC		2	5.00		
IAN 5 72		2	15.00		20.00*
IAN 8 72OC		2	5.00		
IAN 8 72Richardson		2	3.00		28.00*
IAN 10 72Desain		2	3.00		31.00*
IAN 11 72Dota		2	3.00		34.00*
IAN 13 72Richardson		2	3.00		37.00*
IAN 17 72Richardson		2	3.00		40.00*
IAN 18 72OC		2	5.00		
IAN 18 72H. S.		2	3.00		48.00*
IAN 20 72H. S.		2	3.00		51.00*
IAN 21 72H. S.		2	3.00		54.00*
IAN 24 72H. S.		2	3.00		57.00*
IAN 28 72H. S.		2	3.00		60.00*
FEB 1 72H. S.		2	3.00		63.00*
FEB 4 72OC		2	5.00		68.00*
FEB 4 72CR				68.00-	.00*

EXPLANATION OF SYMBOLS

OC - OFFICE CALL
 HO - HOSPITAL CALL
 HV - HOME VISIT

S - SURGERY
 I.J. - INJECTION
 ER - EMERGENCY ROOM

OB - OBSTETRIC
 CR - CREDITS

166422-2

CLAIM DRAFT

MARY E POLLARD
RT 1 COLONIAL CIR
SEYMOUR
TENN 37865

FT SANDERS PRESBYTERIAN
1904 W CLINIC AVE
KNOXVILLE
TN 37916

*****50.00

FILE COPY

5664000 03 05 72 03 29 72*****50.00

637003

H 000050002166422239*

4134266

STATUS WORKSHEET

DEPT #	EMP #	POLICY #	ID	DATE	REG CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESC QUOTE
DUE DATE: / / MODE: EFFECTIVE DATE: / / OCP: PRE BIL: LAST 30 NLT BIL: TYPE: SEX: BIRTH DATE: / / AGE:								NAME: AMOS V FOLLARD JR	
SPEC. FIL. HANDICAP: CASH: DATE LAST TRANS: OTHER: PUBLICATION CODE: IFL: MI: STAT: LAPSE: PREV LAPSE:								ADDRESS: AT 1 COLONIAL CEN	
DATE NEXT EXTRACT: TEST CODE: PREM PAID TO DATE: RATE TABLE: MONTHLY: QUARTERLY: RATES: SEMI ANNUAL: ANNUAL: ST: M: C:								SYMBOL: 37005	
DATE LAST CLAIM PAID: CLAIM PAID: AMOUNT PAID FOR CLAIM: PREMIUM ADJUSTMENT: DATE FOR PREM ADJUST: MULTI-POLICY:								TENN: 37005	
WAIVERS									
DEPENDENTS AND OTHER TRAILERS									
NO	TYPE	NAME	BIRTH DATE	EFF DATE	AGE	RATE \$	MO	QUAR	RATES: 6 ANN
2		MICHAEL V FOLLARD	07/02/70	07/02/70	15	30.00	00	00	00
-ATLS 9.50 27.05 51.30 95.00 2.90 8.25 15.00 29.00									
PREMIUMS TRANS-DATL TYPE AMOUNT DUE/UNAP MTHS UTYPE									
72-03-03 65- 9.50 72-02-26 1									
72-01-29 65- 9.50 72-01-26 1									
73-01-03 65- 9.50 71-12-26 1									
71-11-22 65- 9.50 71-11-26 1									
71-10-29 65- 9.50 71-10-26 1									
71-09-30 65- 9.50 71-09-26 1									
CLAIMS DATE-PAID AMOUNT & DATE-PAID AMOUNT & DATE-PAID AMOUNT &									
71-12-21 .00 P									

DECISION CODE

10	PAY	1	POLICY NUMBER	DATE NOTIFIED	CLAIM NUMBER
20	REJECT - NOT INSURED	6 7	000430	12/20/72	00000
21	REJECT - NO CONFINEMENT/SURGERY	13 14		19 20	2
22	REJECT - LAPSE DUE PAID	SEX	AGE	DATE OF LOSS	POLICY TYPE
23	REJECT - NOT COVERED (CODE)	26	27 28	29	34 35
24	REJECT - PRE EXISTING	37 38	39	40	41
25	REJECT - WAIVER	DECISION CODE	DIAGNOSTIC CODE	DATE CLOSED	
30	RESCIND	41	42 43 44	51 52	5
40	ABANDON	PATIENT NAME (See above)	ID CODE		
50	DUPLICATE				

FORT SANDERS PRESBYTERIAN HOSPITAL

KNOXVILLE, TENNESSEE 37916

HOSPITAL INSURANCE REPORT

NAME OF POLICYHOLDER POLLARD, AMOS V. JR POLICY NUMBER 5664036
R. 1, COLONIAL CIRCLE SEYMOUR, TN.. 37862

EMPLOYED BY INDIV.

NATIONAL HEALTH PLAN
 VALLEY FORGE, PA. 19481

NAME OF PATIENT POLLARD, MARY E

RELATIONSHIP WIFE AGE 27

Admitted 3-5-72

Discharged 3-8-72

Complaint _____ Date of Onset _____

Final Diagnosis, including Complications UTERINE PREGNANCY DEL. TBLC FOOTLING BRECK. FEMALE

Attending Physician/Surgeon H.D.R. CLINIC MD Address KNOXVILLE, TENN SSEE

Operations and Date Performed DELIVERY

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release the information requested on this form. Date 3-17-72 19____ Signed Mary E. Pollard Patient (parent if minor)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize NATIONAL HEALTH PLAN, INS. CO.

to make payment directly to the above named hospital of the hospital benefits herein specified and otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this assignment.

Date 3-17-72 19____

Signed Amos V. Pollard Insured

HOSPITAL CHARGES (Complete this section or attach copy of itemized bill showing type of accommodations.)

ROOM & BOARD

☐ Ward _____ days at \$ _____ Total \$ _____
☐ Semi-private " " \$ _____ " " \$ _____
☐ Private " " \$ _____ " " \$ _____

AVG. SEMI RATE

46.00

SEE ATTACHED STATEMENT

IRS # CA 620528340N

OTHER CHARGES

Anesthesia _____ \$ _____
 Operating or Delivery Room _____ \$ _____
 Laboratory _____ \$ _____
 X-ray _____ \$ _____
 Dressing _____ \$ _____
 Drugs _____ \$ _____
 Oxygen _____ \$ _____
 EKG-BMR _____ \$ _____
 _____ \$ _____
 _____ \$ _____
 Total \$ _____

ASSIGNMENT
 HAS BEEN TAKEN
 BY HOSPITAL

Hospital FORT SANDERS PRESBYTERIAN HOSPITAL Address 1909 WEST CLINCH AVENUE KNOXVILLE, TENNESSEE 37916

Taken from records on 3-17-72 19____ Signed by U. Clout INS. CLERK

STATEMENT

FT. SANDERS PRESBYTERIAN HOSPITAL

1909 W. CLINCH AVE. KNOXVILLE, TENN. 37916

PATIENT POLLARD, MARY E

PATIENT NO.

0918805

204-5

ADMITTED

03/05/72

DISCHARGED

03/08/72

PAGE

2

MAIL TO: AMOS V POLLARD
RT 1 COLONIAL CR
SEYMOUR TENN

37862.

INSURANCE COMPANY

GROUP
NUMBER

POLICY
NUMBER

DAYS

ROOM ALLOWANCE

COVERAGE LIMITS

DEDUCTIBLE
AMOUNT

20470441
6837621001

2

46.00

46.00
46.00

00.00
00.00

DATE	CHARGE DESCRIPTION	TOTAL CHARGES	ESTIMATED INSURANCE COVERAGE		ESTIMATED AMOUNT PAYABLE BY PATIENT
			1ST COMPANY	2ND COMPANY	
	SUMMARY OF CHARGES BY DEPARTMENT				
	NURSERY	44.00	44.00	44.00	44.00
	CENTRAL SUPPLY	8.75	8.75	8.75	8.75
	LABOR + DELIVERY	76.00	76.00	76.00	76.00
	ANESTHIOLOGY MATRL	7.50	7.50	7.50	7.50
	RADIOLOGY	8.00	8.00	8.00	8.00
	LABORATORY	9.00	9.00	9.00	9.00
	PHARMACY	15.50	15.50	15.50	15.50
	BLOOD AND PLASMA	17.00	17.00	17.00	17.00
3	DAYS-SEMI-PRIVATE	138.00	138.00	138.00	138.00
	TOTAL CHARGES	323.75	323.75	323.75	323.75
					.00
					.00
	ASSIGNMENT HAS BEEN TAKEN BY HOSPITAL				
		323.75	323.75	323.75	323.75

IMPORTANT: A CREDIT BALANCE IN PATIENT PAY COLUMN INDICATES AMOUNT TO BE REFUNDED WHEN YOUR INSURANCE COMPANIES PAY THE HOSPITAL.

THE INSURANCE ESTIMATE SHOWN ABOVE MUST BE APPROVED BY YOUR INSURANCE CARRIER AND IS SUBJECT TO CHANGE.



PATIENT PAY
THIS
AMOUNT

PS.

NAME OF PATIENT

Michael V. Pollard 2

POLICY NUMBER 5664036

12 15

71

H214405

DATE OF LOSS

11 28 71

DATE NOTIFIED

M 03 WFS

CLAIM NO

S

CODE SYMBOLS

FOLLOW UP

ADJUSTOR

WANTED

FORM LETTERS TO BE SENT.

SMR

BE 3 (f)

BE 5 (m) to

ANC to

Auth. Needed

Claim Form P.O. Side

Claim Form OR Side

Hospital Records

Hospital Bill

Info Letter

IS DL Letter

Retail Credit

See Instructions

SPECIAL INSTRUCTIONS:

10 ☐ PAY11 ☐ PAY - WAV. BEFORE PAY12 ☐ PAY - WAV. AFTER DEC.21 ☐ REJ. - NO CONFINEMENT22 ☐ REJ. - POLICY LAPSE23 ☒ REJ. - NOT INSURED COVER24 ☐ REJ. - PRE EXISTING25 ☐ REJ. - WAVERED30 ☐ RESCIND40 ☐ ABANDON50 ☐ DUPLICATE60 ☐

NATIONAL HOME LIFE ASSURANCE CO.

CLOSING

4 MO. DAY YR 12 21 71 ☐ YES ☐ PARTIAL ☐ NO ☐ COMPLETE ☐ WAIVER ADDED ☐ ADD'L

MO. DAY YR DRAFT NO. DRAFT DATE TOTAL AMOUNT

Hosp. Days at / \$
 Conv. Days at /
 Dr. visits at /
 Nurse visits at /
 Days Dis. Inc. at /

ment
 Death

TYPE

Hosp. Days at /
 Conv. Days at /
 Dr. visits at /
 Nurse visits at /
 Days Dis. Inc. at /

TOTAL

01 ☐ PAYEE AS ABOVE

02

03

04

05

06

07

08

09

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

NAME AND ADDRESS

Adjustor No.

614

EAST TENNESSEE BAPTIST HOSPITAL
KNOXVILLE, TENNESSEE
HOSPITAL INSURANCE REPORT

ACCOUNT NUMBER

1198750

National Home Life Assurance Co.

POLICY IDENTIFICATION NUMBER

62-0506166

PLEASE REFER TO THIS NUMBER FOR REMITTANCE

DEC 14 1911-300

NAME OF POLICYHOLDER Amos Pollard POLICY NUMBER 5664036
 EMPLOYED BY Neely Produce Route # 2 Seymour Tennessee.
 NAME OF PATIENT (if other than policyholder) Michael Pollard
 RELATIONSHIP son
 ADMITTED 11 28 71 of 4 25 p.m. DISCHARGED 11 30 71 200PM of 6 a.m.
 FINAL DIAGNOSIS, INCLUDING COMPLICATIONS Tonsillitis

ATTENDING PHYSICIAN/SURGEON Dr. Cross Christian ADDRESS Knoxville Tennessee.
Zirkle & Long Surgery
 OPERATIONS AND DATE PERFORMED _____

HOSPITAL CHARGES (Complete this section or attach copy of itemized bill showing type of accommodations.)

ROOM & BOARD	<input type="checkbox"/> Private	2 days at \$	16 00	Total \$	92 00
	<input type="checkbox"/> Semi-private	" " \$	" "	" "	" "
	<input type="checkbox"/> Nurses	" " \$	" "	" "	" "
	<input type="checkbox"/> Operating or delivery room				50 00
OTHER CHARGES	Anesthesia				11 50
	Laboratory				21 00
	X-ray				
	Medical and Surgical Supplies				2 75
	Drugs				7 00
	Oxygen				
	Physical Therapy				
	EKG				
	Blood Bank				
	Transfusion, Setup				
	Recovery room				4 00

AVERAGE
SEMI-PRIVATE RATE

43 00

HOSPITAL EAST TENNESSEE BAPTIST HOSPITAL ADDRESS KNOXVILLE, TENNESSEE 37901
 TAKEN FROM RECORDS ON 12 7 71 SIGNED BY Ins CLK

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release the information requested on this form. DATE 11-28-71 Signed [Signature] Patient (parent if minor)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize _____ to make payment directly to the above named hospital of the hospital benefits herein specified and otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this assignment.

DATE 11-28-71 Signed [Signature] INSURED

EAST TENNESSEE BAPTIST HOSPITAL
KNOXVILLE, TENNESSEE
HOSPITAL INSURANCE REPORT

ACCOUNT NUMBER

1198750

PLEASE REFER TO THIS
NUMBER FOR REMITTANCE

National Home Life Assurance

NAME OF POLICYHOLDER Amos Pollard POLICY NUMBER 5664036EMPLOYED BY Route # 2 Seymour Tennessee.NAME OF PATIENT (IF OTHER THAN POLICYHOLDER) Michael PollardRELATIONSHIP SONADMITTED 11 28 71 at 4 25 PM p.m. DISCHARGED 11 30 71 at 200PM a.m. p.m.FINAL DIAGNOSIS, INCLUDING COMPLICATIONS TonsillitisATTENDING PHYSICIAN/SURGEON Dr. Cross Christian ADDRESS Knoxville Tennessee.OPERATIONS AND DATE PERFORMED Zirkle & Long Surgery

HOSPITAL CHARGES (Complete this section or attach copy of itemized bill showing type of accommodations.)

ROOM & BOARD	<input type="checkbox"/> Private <u>2</u> days at \$ <u>46 00</u> Total \$ <u>92 00</u>
	<input type="checkbox"/> Semi-private " " \$ " " " "
	<input type="checkbox"/> Nursery " " \$ " " " "
OTHER CHARGES	Operating or delivery room \$ <u>50 00</u>
	Anesthesia \$ <u>11 50</u>
	Laboratory \$ <u>21 00</u>
	X-ray \$
	Medical and Surgical Supplies \$ <u>2 75</u>
	Drugs \$ <u>7 00</u>
	Oxygen \$
	Physical Therapy \$
	EKG \$
	Blood Bank \$
Transfusion, Sehp \$	
<u>Recovery room</u> \$ <u>4 00</u>	
	\$

AVERAGE
SEMI-PRIVATE RATE43 00TOTAL \$ 188 25HOSPITAL EAST TENNESSEE BAPTIST HOSPITAL ADDRESS KNOXVILLE, TENNESSEE 37901TAKEN FROM RECORDS ON 12 7 71 SIGNED BY Ans CLK

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release the information requested on

this form DATE 11 28 - 71 Signed Amos Pollard

Patient (parent if minor)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize

to make payment directly to the above named hospital of the hospital benefits herein specified and otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this assignment.

DATE 11 28 71

Signed

Amos Pollard
INSURED

STATUS REPORT

DEPT #		EMP #		POLICY #	ID	DATE		REF CODE	CLAIM REASON		CLAIM #	
1625	0N33	5664036		POL		12/15/71	4					
DUPLICATE DATE		MODE	EFFECTIVE DATE	CURR	PRE BIL	LAST BIL	COG POS BIL	TYPE	SEX	BIRTHDATE	AGE	
71/12/26	9		70/10/26	9	002			WP5	M	43/11/04	26	
SPEC HANDLING	REF CODE	CASH	DATE LAST PAID	OTHER	PUBLICATION CODE				PL	MI STAT	LARGE	FULLY LADY
			71/11/28	71/01/29	0503-7-04							
DATE NET EXTRACT		TEST CODE	PREM PAID TO DATE	RATE CLASS	MONTHLY	QUARTERLY	SEMI ANNUAL	ANNUAL	ST C	PAID		
72/01/23			127.80	00	3.30	9.40	17.82	33.00	41			
DATE LAST CLAIM PAID		CLAIM PAID	AMOUNT PAID FOR CLAIM		PREMIUM ADJUSTMENT		DATE FOR PREMIUM ADJUST		MULTI POLICY			

DEPENDENTS AND OTHER TRAILERS										
NO	TYPE	NAME	BIRTH DATE	EFF DATE	AGE	RATE	VALUES			
							MO	QUART	SANPS	ANIN
1	P5	MARY E POLLARD	44 / 11 /	70 / 10	25	00F0033000940	01	78	20	3300
2	P5	MICHAEL V POLLARD	67 02	70 10	03	00M000000000000	00	00	00	00000
OTHER TRAILERS										
F	2.90	8.25	15.66	29.00						
R	9.50	27.05	51.30	95.00						
DATE	TRAN	DOCU	AMOUNT	FROM	TO	U DATE	U TR	U DOC		
0825	85	2193	9.50	710826	710926					
0930	85	2489	9.50	710926	711026					
1029	85	2572	9.50	711026	711126					
1122	85	2635	9.50	711126	711226					

Effective Date of Change

Check Payable to:

YR						MO				DA		Transaction Code				Location				Reference No			
13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30						

211

Check Route:

 Main Insured

Estate of MI

Field A - New Field NOTE "@" sign must follow last character on transaction # 1 only

31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Field B - Old Field NOTE "@" sign must follow last character on transaction # 1 only

56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

f = planation

Approved by _____

1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 26

NATIONAL HOME

ROUTING SLIP

NATIONAL HOME

B3

{ } Mr. Name Ann Sallard Jr Re: _____
 { } Mrs. Address Lt 1 Colonial Ck Rd Policy # 5664036
 { } Miss Lynn, Tenn 37865 5664036

ROUTING TO: Research Claim POS-Letter Underwriting

Wats PC-BBK _____ Return To _____ Per _____ Date 11/18/71CLERICAL POOL: Membership Card ☐ Duplicate Policy ☐ Renewal Premium Card ☐

AUTO-TYPE INSTRUCTIONS

Opening _____ Closing _____ Main Letter Series 3-14

A. Insert _____

B. Insert _____

2. Insert Copies are being corrected as you have requested. The due date of the policy is 12/2-6/70 and the monthly rate is \$9.50.

Stop Codes 1. 5664036 2. Ann Sallard Jr
Mary E Sallard 4. Michael Sallard
 5. _____ 6. _____
 7. _____ 8. _____
 9. _____ 10. _____

() Enclosure () File Alpha (☒) File Numeric () Claim Slip

() Destroy All () Life Suspense () Return 85 RW

Per MT Date 4/14

POS-33

8.35

National Home Health Plan

I write to you some time ago about my policy. Whenever we took out our policy, we sent in a check for the amount of \$9.50 which was to cover me, my wife, little boy and also maternity benefits. However the next time we received our payment notice, the payment was only for \$8.35. Could you explain to us why the maternity benefits were cancelled? Please write to us immediately as we would prefer to have these benefits included in our policy.

Thank you,
Amos Pellard, Jr.

NATIONAL HEALTH PLAN

VALLEY FORGE, PA. 19481
POLICY CHANGE ENDORSEMENT

NAME OF INSURED	POLICY NUMBER	EFFECTIVE DATE OF CHANGE
Amos V. Billard Jr.	5664036	71-01-14

It is hereby agreed and understood that your policy plan is changed to a Family Plan with maternity benefits.

John C. Keane
Secretary

NATIONAL HOME LIFE ASSURANCE CO.
Valley Forge, Pennsylvania

PREMIUM INFORMATION	CHANGE TO			
<input type="checkbox"/> NO CHANGE	MONTHLY	QUARTERLY	SEMI-ANN	ANNUALLY

PLEASE ATTACH THIS
ENDORSEMENT TO YOUR POLICY

UNDH-43

STATUS REPORT

DEPT #	EMP #	POLICY #	ID	DATE	REF CODE	CLAIM REASON	CLAIM #	DEF QUOTE	RESC QUOTE	
1000	1000	1000	1000	11/12/71	6					
NAME								N H L		
DUE DATE								7/1/72		
MODE								700		
EFFECTIVE DATE								1/72		
OCP								100		
PRE BILL								100		
POST BILL								100		
TYPE								WP4		
SEX								M		
BIRTH DATE								11/16/25		
AGE								46		
DATE LAST TRANS								7/1/72		
CASH								100		
OTHER								100		
PUBLICATION CODE								100		
IFL								100		
MI								100		
LAPSE								100		
PREV LAPSE								100		
DATE NEXT EXTRACT								7/1/72		
TEST CODE								100		
PREM PAID TO DATE								100		
RATE TABLE								100		
MONTHLY								100		
QUARTERLY								100		
SEMI ANNUAL								100		
ANNUAL								100		
ST M C								100		
DATE LAST CLAIM PAID								7/1/72		
CLAIM PAID								100		
AMOUNT PAID FOR CLAIM								100		
PREMIUM ADJUSTMENT								100		
DATE FOR PREM ADJUST								7/1/72		
MULTI-POLICY								100		
WAIVERS								100		
DEPENDENTS AND OTHER TRAILERS								100		
NO	TYPE	NAME	BIRTH DATE	EFF DATE	AGE	RATE	MO	QUAR	S ANN	ANN
1	DA	MARY E POLLARD	44/11/77	77/10/25	25	100	100	100	100	100
2	DA	MICHAEL V POLLARD	67/02/70	70/10/03	10	100	100	100	100	100
OTHER TRAILERS										
F 1.75 4.38 9.45 17.50										
R 3.35 23.78 45.09 83.50										
Z01 710304 77 710126 5.75 16.37 31.05 57.50 4.79 710226										
Z02 71027 84 1.15										
DATE	TRAN	DOCU	AMOUNT	FROM	TO	U DATE	U TR	U DEC		
1725	84		9.50	701025	701126					
1130	85	5504	8.35	701126	701226					

71-01-14

Fam - W Trial

8.35
1.15
9.50

23.78
3.35
27.43

45.09
6.21
51.30

83.50
11.00
94.50

Effective Date of Change

YR	MO	DA
13	14	15
16	17	18

Transaction Code

19	20	21	22
----	----	----	----

Location

23	24	25	26
----	----	----	----

Reference No

27	28	29	30
----	----	----	----

Check Payable to:

_____	NLL	Check Route
_____	Main Insured	
_____	Estate of MI	

Field A - New Field NOTE "@" sign must follow last character on transaction #1 only

31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Field B - Old Field NOTE "@" sign must follow last character on transaction #1 only

56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Explanation

Approved by

Prepared by

Date

STATUS WORKSHEET

DEPT #	EMP #	POLICY #	ID	DATE	RED CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESC QUOTE
								NAME	
								ADDRESS	
DUE DATE	MODE	EFFECTIVE DATE	OCF	PRE BILL	LAST PD NO BILL	TYPE	SEX	BIRTH DATE	AGE
SPEC REF HAND CODE	CASH	DATE LAST TRANS	OTHER	PUBLICATION CODE			IFL	MI STAT	PREV LAPSE
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	RATES	SEMI ANNUAL	ANNUAL	ST C
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST	MULTI-POLICY				
WAIVERS									
DEPENDENTS AND OTHER TRAILERS									
NO	TYPE	NAME			BIRTH DATE	EFF DATE	AGE	RATE \$	RATES
									MO QUAR S ANN ANN

DECISION CODE

10	PAY	1	POLICY NUMBER	DATE NOTIFIED	CLAIM NUMBER
20	REJECT - NOT INSURED	6 7	13 14	19 20	25
21	REJECT - NO CONFINEMENT/SURGERY	SEX	AGE	DATE OF LOSS	POLICY TYPE
22	REJECT - LAPSE DUE PAID	26 27 28 29	34 35	37 38	40
23	REJECT - NOT COVERED (CODE)	DECISION CODE	DIAGNOSTIC CODE	DATE CLOSED	
24	REJECT - PRE EXISTING	41 42 43 44	51 52	57	
25	REJECT - WAIVER				
30	RESCIND				
40	ABANDON	<input type="checkbox"/> PARTIAL	VOID DEP #	PATIENT NAME (See above)	ID CODE
50	DUPLICATE	<input type="checkbox"/> COMPLETE			
60	OTHER	<input type="checkbox"/> ADD'L	58 59 60 61	85 86 88	

BENEFITS FOLDER

HEALTH INSURANCE CLAIM — GROUP OR INDIVIDUAL

PART A

TO BE COMPLETED BY PATIENT (INSURED)

COMB 1 (10-67)

Spaced for Typewriter — Marks for Tabulator Appear on this Line

PATIENT'S NAME AND ADDRESS Bobbie XXXX Wilson Jesup, Iowa		DATE OF BIRTH
INSURED'S NAME IF PATIENT IS A DEPENDENT Dorothy		
NAME OF INSURANCE COMPANY National Home Life	POLICY NUMBER 5596983	INSURED'S SOCIAL SECURITY NUMBER
IF GROUP INSURANCE, NAME OF POLICYHOLDER (i.e. Employer, Union or Association through whom insured)		

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

SIGNED (INSURED PERSON)

Mrs. Dorothy Wilson DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

SIGNED (PATIENT, OR PARENT (if MINOR))

Mrs. Dorothy Wilson DATE

PART B

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS

(IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME):

Left ureteral stone with hematuria

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☒

PREGNANCY?

YES ☐ NO ☐

IF YES, APPROXIMATE DATE PREGNANCY COMMENCED, DATE

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE — IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES
3-7-72 to 3-9-72	Hospital	Hospital medical care		34.50
3-17-72	Off	Office exam 5.00 UA 2.00		7.00
3-30-72	Off	Office exam and UA		7.00

TOTAL CHARGES ▶ \$ 48.50

AMOUNT PAID ▶ \$ none

BALANCE DUE ▶ \$ 48.50



IO—Doctor's Office

IH—Inpatient Hospital

NH—Nursing Home

H—Patient's Home

OH—Outpatient Hospital

OL—Other Locations

*ICDA—International Classification of Diseases

**CPT—Current Procedural Terminology (current edition)

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

3-7-72

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

3-7-72

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES ☐ NO ☒

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK).

FROM THRU

8. PATIENT WAS PARTIALLY DISABLED.

FROM THRU

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

11. PATIENT WAS HOUSE CONFINED.

FROM THRU

12. DOES PATIENT HAVE OTHER HEALTH COVERAGE?

YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY

13. I DO NOT ACCEPT ASSIGNMENT.

DATE PHYSICIAN'S NAME (PRINT)

5-16-72 Dr. L.J. Flage

SOCIAL SECURITY NUMBER

42-0920-804

PHYSICIAN'S SIGNATURE

DEGREE

TELEPHONE

334-2541

STREET ADDRESS

CITY OR TOWN

STATE OR PROVINCE

ZIP CODE

801 1st E Independence, Iowa 50644

STATUS WORKSHEET

DEPT #	EMP #	POLICY #	ID	DATE	REC CODE	CLAIM REASON	CLAIM #	REF QUOTE	RESC QUOTE
								NAME	
								ADDRESS	
DUE DATE	MODE	EFFECTIVE DATE	OCP	PRE-BILL	LAST DO NOT BILL	TYPE	SEX	BIRTH DATE	AGE
SPEC. REL. HAND. CODE	CASH	DATE LAST TRANS	OTHER	PUBLICATION CODE			IFL	MI STAT	PREV LAPSE
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	RATES	SEMI ANNUAL	ANNUAL	ST M C
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE FOR PREM ADJUST		MULTI-POLICY			
WAIVERS									
DEPENDENTS AND OTHER TRAILERS									
NO	TYPE	NAME	BIRTH DATE	EFF DATE	I	AGE	RATE	S	RATES
							MO	QUAR	5 ANN
									ANN

DECISION CODE

10	PAY	1	POLICY NUMBER	DATE NOTIFIED	CLAIM NUMBER
20	REJECT - NOT INSURED	6 7	13 14	19 20	25
21	REJECT - NO CONFINEMENT/SURGERY	SEX	AGE	DATE OF LOSS	POLICY TYPE
22	REJECT - LAPSE DUE PAID	26	27 28	29	34 35
23	REJECT - NOT COVERED (CODE)	DECISION CODE	DIAGNOSTIC CODE	DATE CLOSED	ADJUSTER NO.
24	REJECT - PRE EXISTING	41	42	43 44	51 52
25	REJECT - WAIVER	VOID	DEP	PATIENT NAME (See above)	ID CODE
30	RESCIND	41	42	43 44	51 52
40	ABANDON	<input type="checkbox"/> PARTIAL	<input type="checkbox"/> COMPLETE	<input type="checkbox"/> ADD'L	
50	DUPLICATE	58	59	60 61	85 86 87
60	OTHER				

1										DUPLICATE		5	6	7	DUPLICATE		13	14	15	
DATE	TIME	AMOUNT	COUNT							2										
HOS	01									16	COMMENTS									21
DAYS	02									22										35
CONV	03									36										49
DAYS	04									50										63
DR	05									64										77
VISIT	06									78										88
NR	07									89										102
VISIT	08									103										114
DAYS	09									115										128
DIS	10									129										140
SUR	11									141										154
DIS	12									155										164
MEM	13									165										178
A	14									179										189
D	15																			
DRAFT #1 AMOUNT																				
2										DUPLICATE		5	6	7	DUPLICATE		13	14	15	
DATE	TIME	AMOUNT	COUNT							2										
HOS	01									16	COMMENTS									21
DAYS	02									22										35
CONV	03									36										49
DAYS	04									50										63
DR	05									64										77
VISIT	06									78										88
NR	07									89										102
VISIT	08									103										114
DAYS	09									115										128
DIS	10									129										140
SUR	11									141										154
DIS	12									155										164
MEM	13									165										178
A	14									179										189
D	15																			
DRAFT #2 AMOUNT																				
REASON #1 (90-106)										REASON #2 (107-123)										
REASON #3 (124-140)										REASON #4 (141-174)										
REASON #5 (175-208)										REASON #6 (209-215)										
RETURN CHECK(S) TO										BES(M) TO										
ANC TO										SMR										
BES(M)										TOTAL AMOUNT THIS CLAIM										

INDIVIDUAL HOSPITAL INSURANCE FORM

Spaced for Typewriter — Marks for Tabulator Appear on this Line

HOSPITAL COMPLETE FOLLOWING TO AND FURNISH COPY TO		National Home Life Assur.		ADDRESS Valley Forge, Pennsylvania 19481	
NAME OF POLICYHOLDER Dorothy Wilson		POLICY NUMBER(S) 5596983			
ADDRESS—STREET AND NUMBER RR 2		CITY Jesup		STATE Iowa	PHONE
NAME OF PATIENT (IF OTHER THAN POLICYHOLDER) 17 14					
DATE ADMITTED 3/7/72		TIME ADMITTED AM PM		DATE DISCHARGED 3/9/72	
TIME DISCHARGED AM PM					
OTHER INSURANCE INDICATED BY HOSPITAL RECORDS. IF YES NAME OF COMPANY. <input type="checkbox"/> NO <input type="checkbox"/> YES					
COMPLAINT					

DATE OF FIRST SYMPTOMS

DIAGNOSIS FROM RECORDS (If Injury, Give Date and Place of Accident)

..Left ureteral stone, passed. Hematuria, secondary to #1

OPERATIONS OR OBSTETRICAL PROCEDURES PERFORMED (Nature and Date)

HOSPITAL CHARGES (Complete This Section or Attach Copy of Itemized Bill Showing Information Below)				TOTAL CHARGES	
ROOM AND BOARD	WARD	DAYS AT \$	TOTAL \$		
	<input checked="" type="checkbox"/> SEMI-PRIVATE	2 DAYS AT \$36	TOTAL \$ 72.00		
	<input type="checkbox"/> PRIVATE	DAYS AT \$	TOTAL \$		
	<input type="checkbox"/> OTHERS	/	\$		
OTHER CHARGES	OPERATING OR DELIVERY ROOM				
	ANESTHESIA				
	X-RAY 72.00				
	LABORATORY 63.00				
	E K G B M R				
	PHYSICAL THERAPY				
	AMBULANCE				
	MEDICAL AND SURGICAL SUPPLIES 3.00				
	PHARMACY [Except Test Home Drugs] 5.00				
	INHALATION THERAPY				
INTRAVENOUS SOLUTIONS					
TOTAL \$ 215.00					

Dorothy Wilson
RR 2
Jesup, Iowa

Dr. L. J. Flage
801 1st East
Independence, Iowa 50644

THIS FORM APPROVED BY THE HEALTH
INSURANCE COUNCIL AND ACCEPTED
BY THE AMERICAN HOSPITAL ASSOCIATION
FOR USE BY HOSPITALS.



HIF-1 (11961)

HOSPITAL Peoples Memorial Hospital	ADDRESS Independence, Iowa 50644
TAKEN FROM RECORDS ON 3/25/72	SIGNED BY <i>William J. Flage</i>

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release information requested on this form.

Date 3-7-72 Signed *Miss Dorothy Wilson* Patient (Parent if a Minor)

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment directly to the above named hospital of the Hospital Benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this authorization.

Date 3-7-72 Signed *Miss Dorothy Wilson* (Policyholder)

FILE No. 5 60 8254

This file is a fun one in answer to our "finger chopper" witness of last time. In this instance two policyholders with the same name were confused and a Detroit, Michigan, policyholder received a card saying that the company was processing his claim; when, in fact, it was a St. Louis policyholder of the same name making the claim.

The Detroit policyholder writes as follows:

"I just received this card in the mail saying you are processing a claim for me immediately. But I must say somewhere or somehow you have gotten your records or your files mixed up as I am not sick and pray to Jehovah I will not get sick. I have not filled out a blank for a sick claim, last week I did send you a check for \$23.79. I think it was, but it was for my payment on my insurance for so please don't make me a claim as I am not entitled to anything as I am perfectly well. Please check the mistake, maybe it was someone else. I appreciate you doing your duty or job. But please check your files again. And at once let me know where the mistake is as I am not sick. And I do like honesty and believe in being honest. Please don't send me any money or a check for money. Thank you for everything and thanks for promptness."

It is interesting to note that the legitimate claim was rejected as not being covered and that person was a 78 year old male who was confined in the hospital from January 9, 1971, to January 12, 1971, for coronary insufficiency. It is believed that this rejection of the claim was because there was a 3-day exclusion in the contract.

NAME AND ADDRESS OF PATIENT
George R. Jordan 1

5608254 02 09 71 H063628

FORM LETTERS TO BE SENT:
SMR
DE 3 (1)
BF 5 (m) to
ANC to

POLICY NUMBER
DATE OF LOSS
SEX
AGE
TYPE
CLAIM NO.
CODE SYMBOLS

01 09 71 M 78 WPS S

MO DAY YR

FOLLOW UP	ADJUSTOR	WANTED
		Auth. Needed
		Claim Form P.O. Side
		Claim Form DR Side
		Hospital Records
		Hospital Bill
		Stall Letter
		IS DL Letter
		Retail Credit
		See Instructions

UR
2-16-71

SPECIAL INSTRUCTIONS:

	10 <input type="checkbox"/> PAY
	11 <input type="checkbox"/> PAY - WAY. BEFORE PAY
	12 <input type="checkbox"/> PAY - WAY. AFTER DEC.
	21 <input type="checkbox"/> REJ. NO CONFINEMENT
	22 <input type="checkbox"/> REJ. POLICY LAPSE
	23 <input type="checkbox"/> REJ. NOT INSURED/COVER
	24 <input type="checkbox"/> REJ. PRE EXISTING
	25 <input type="checkbox"/> PRE. WAIVED
	26 <input type="checkbox"/> PRESCIND
	45 <input type="checkbox"/> ABANDON
	50 <input type="checkbox"/> DUPLICATE
	<input type="checkbox"/> LE
	<input type="checkbox"/> NON-LE

345

NATIONAL HOME LIFE ASSURANCE CO.

CLOSING

DIAGNOSTIC CODE	MO	DAY	YR	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> PARTIAL	<input type="checkbox"/> COMPLETE	<input type="checkbox"/> ADD'L	DRAFT NO	DRAFT DATE	TOTAL AMOUNT
3	2	19	71	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> PARTIAL	<input type="checkbox"/> COMPLETE	<input type="checkbox"/> ADD'L			

BASE

_____ Hosp. Days at _____ / _____	01 <input type="checkbox"/> PAYEE AS ABOVE
_____ Conv. Days at _____ / _____	02
_____ Dr. visits at _____ / _____	03 <input type="checkbox"/> OTHER
_____ Nurse visits at _____ / _____	04
_____ Days Dis. Inc. at _____ / _____	05 NAME AND ADDRESS
Surgery	06
Dismemberment	07
Accidental Death	08

RIDER

TYPE

_____ Hosp. Days at _____ / _____	31
_____ Conv. Days at _____ / _____	32
_____ Dr. visits at _____ / _____	33
_____ Nurse visits at _____ / _____	34
_____ Days Dis. Inc. at _____ / _____	35
Surgery	36
Dismemberment	37
Accidental Death	38

ADJUSTOR NO.

INDIVIDUAL HOSPITAL INSURANCE FORM

5608254?

0-63

Hospital Complete and Furnish Copy To

National Home Life Insurance

Address

4242 Lindell Blvd., St. Louis, Mo.

Name of Policyholder

Policy Number(s)

George R. Jordan

M1608-08 GRH68637

Address Street and Number

City

State or Province

2288 Lanai Ave.

Largo

Florida 33540

Name of Patient (If other than policyholder)

Age

78

Date Admitted

Time Admitted

AM

Date Discharged

Time Discharged

AM

01/09/71

4:45 PM

PM

01/12/71

10:35 AM

PM

Other Insurance Indicated by Hospital Records. If YES name of Company

☐ NO☐ YES

Complaint

Date of First Symptoms

Diagnosis from Records (If Injury give date, Place of accident)

Acute Coronary Insufficiency

Operations or Obstetrical Procedures Performed (Nature and Date)

HOSPITAL CHARGES (Complete this section or attach copy of itemized bill showing information below.)

ROOM AND BOARD	<input checked="" type="checkbox"/> WARD 3 DAYS AT \$ 36 TOTAL \$ 108.00	TOTAL CHARGES \$ 221.30
	<input type="checkbox"/> SEMI-PRIVATE DAYS AT \$ TOTAL \$	
	<input type="checkbox"/> PRIVATE DAYS AT \$ TOTAL \$	
	<input type="checkbox"/> OTHER \$	
OTHER CHARGES	OPERATING OR DELIVERY ROOM	\$
	ANESTHESIA	\$
	X-RAY	\$
	LABORATORY	\$
	EKG BMR	\$
	PHYSICAL THERAPY	\$
	AMBULANCE	\$
	MEDICAL & SURGICAL SUPPLIES	\$
	PHARMACY, EXCEPT TAKE HOME DRUGS	\$
	INHALATION THERAPY	\$
TOTAL \$ 221.30		

THIS FORM APPROVED BY THE
HEALTH INSURANCE COUNCIL
AND ACCEPTED BY THE AMERICAN
HOSPITAL ASSOCIATION
FOR USE BY HOSPITALS (see
explanatory instructions).



HOSPITAL

MORTON F. PLANT HOSPITAL

ADDRESS

CLEARWATER, FLORIDA

SIGNED BY

TAKEN FROM RECORDS ON Jan. 20, 1971

1971

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release information requested on this form.

Date 01/09/71, 19

Signed

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment directly to the above named hospital of the Hospital Benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered

MORTON F. PLANT HOSPITAL

223 JEFFERSON STREET P.O. BOX 210 CUNAWATER, FLORIDA 33517
PHONE (813) 446-7111

PATIENT'S STATEMENT

PATIENT NAME: JORDAN, GEORGE R

072047-4

MORROW

025 3

01-09-71

01-12-71

ILL TO: GEORGE R JORDAN
2288 LANAI AVE
LARGO, FL 33540

312032330A

CONTACT

GROUP

TYPE

STATE

EFFECTIVE DATE

DOCTOR: WALKER, ROBERT P

6

SUBSCRIBER

INSURANCE COMPANIES

MEDICARE

DATE MO. DAY	DESCRIPTION	REFERENCE NUMBER	CHARGES	PAYMENTS	ESTIMATED INS. COVERAGE		ESTIMATED DUE FROM PATIENT
					1st COMPANY	2nd COMPANY	
	RECAP AS OF 01-15-71 3 DAYS 025-3 HAD		108 00				
	16 ELECTROCARDIOGRAM		40 00				
	15 INHALATION THERAPY		3 50				
	06 LABORATORY		59 95				
	13 MED. & SURG. SUPPLIES		2 75				
	10 PHARMACY & I.V.		7 10				
OTHER INSURANCE ESTIMATE			221 30				221 30-

THIS STATEMENT MAY HAVE TO BE ADJUSTED TO REFLECT CHARGES OR CREDITS RECEIVED IN THE BUSINESS
PERIOD AFTER DISCHARGE. ALL STATEMENTS ARE DUE WITHIN 90 DAYS. PLEASE SEE REVERSE SIDE.

MORTON F. PLANT HOSPITAL

323 JEFFERDS STREET P.O. BOX 210 CLEARWATER, FLORIDA 33517
PHONE (813) 446-7111

PATIENT'S STATEMENT

PATIENT NAME: JORDAN, GEORGE R

022047-4

MORROW

025 3

01-09-71

01-12-71

L TO: GEORGE R JORDAN
2288 LANAI AVE
LARGO, FL 33540

312032330A

CONTRACT

GROUP

TYPE

STATE

EFFECTIVE DATE

1

CTOR: WALKER, ROBERT P

6

SUBSCRIBER

INSURANCE COMPANIES

MEDICARE

DATE MO. DAY	DESCRIPTION	REFERENCE NUMBER	CHARGES	PAYMENTS	ESTIMATED INS. COVERAGE		ESTIMATED DUE FROM PATIENT
					1st COMPANY	2nd COMPANY	
1 09	10 DRUG		1 65				
1 09	C1 ROOM 025-3		36 00				
1 10	16 E.C.G.	101	20 00				
1 10	C6 LAB	516	9 35				
1 10	C6 LAB	517	16 50				
1 10	C6 LAB	518	15 40				
1 10	13 C.S.S.	260	2 75				
1 10	10 DRUG	686	3 45				
1 10	10 DRUG	794	1 25				
1 10	C1 ROOM 025-3		36 00				
1 11	15 I.T.	959	3 50				
1 11	C6 LAB	388	15 40				
1 11	C6 LAB	434	3 30				
1 11	10 DRUG	1782	75				
1 11	C1 ROOM 025-3		36 00				
1 12	16 E.C.G.	1118	20 00				
OTHER INSURANCE ESTIMATE			221 30				

THIS STATEMENT MAY HAVE TO BE ADJUSTED TO REFLECT CHARGES OR CREDITS RECEIVED IN THE BUSINESS
OFFICE AFTER DISCHARGE. ALL STATEMENTS ARE DUE WHEN PRESENTED. PLEASE SEE REVERSE SIDE.

STATUS REPORT

DEPT #	EMP #	POLICY #	ID	DATE	REF #	CLAIM #	CLAIM #
1625	OK49	5608254	JUR	02/09/71	4		
DUE DATE	WIFE	EFFECTIVE DATE	YOB	REL	TYPE	SEX	BIRTH DATE
71/02/13	4	70/10/13	9	001	WP3	F	22/06/10 48
CASH	DATE LAST TRANS	OTHER	PUBLICATION CODE	FEI	MI	STAT	PREV LARVE
	70/11/19	70/10/13	2-0686-6-7				
DATE NEXT EXTRACT	TEST CODE	PREM PAID TO DATE	RATE TABLE	MONTHLY	QUARTERLY	WEEKLY	SEMI ANNUAL
71/02/27		24.04	00	3.60	10/26	19.44	36.0021
DATE LAST CLAIM PAID	CLAIM PAID	AMOUNT PAID FOR CLAIM	PREMIUM ADJUSTMENT	DATE OF PREM	W	MULTI POLICY	
WAIVERS							

DEPENDENTS AND OTHER TRAILERS										
NO	TYPE	NAME	BIRTH DATE	EFF DATE	AGE	RATE \$	MO	DUAR	SATN	ANN
1	P3	GEORGE R JORDAN	99/01/70	10/10/71	00	475	0135	3025	6504	750
OTHER TRAILERS										
R	8.35	23.79	45.09	83.50						
DATE	TRAN	DUOU	AMOUNT	FROM	TO	U DATE	U TR	U DOC		
1013	84		0.25	701013	701113					
1110	85	5584	23.79	701113	710213					

Effective Date of Change

YR	MO	DA
13	14	15
16	17	18

Transaction Code

19	20	21	22
----	----	----	----

Location

23	24	25	26
----	----	----	----

Reference No

27	28	29	30
----	----	----	----

Check Payable to

NLL	Check Route
Main Insured	
Estate of MI	

Field A - New Field NOTE "@" sign must follow last character on transaction #1 only

31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Field B - Old Field NOTE "@" sign must follow last character on transaction #1 only

56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Explanation

Approved by

Prepared by

Date

NO ANSWER NEEDED.
CROSSED OUR 2/16
FILED

By Deft 2/23/77 Lawrence
Smith 48202

Dear Sir:

I just received this Card in the mail saying you are processing a Claim for me immediately. But I must say some where or some how you have gotten your records or your files mixed up as I am not sick and pray to Jehova I will not get sick I have not filled out a blank for a sick Claim, last week I did send you a Check for \$ 23.79 I think it was But it was for my Payment on my insurance for me a Claim as I am not entitle to any thing as I am perfectly well. please Check the mistake maybe it was done one else. I appreciate you doing your duty on job. But please, check your file again And at once let me know where the mistake is as it is not right.

and I do like honesty and
 honesty in being honest. please
 don't send me any money
 or a check for now.
 Thank for every thing and thanks
 for pro. & p. n. s.

Truly yours
 Margaret Gardener.

Mr. SHARP. Mr. Chairman, I would like to close by introducing these documents, just briefly. We would like to introduce for the record, National Liberty Corp.'s various policies and advertising material and current premium payment modes. The National Liberty Corp. prospectus, dated August 26, 1971, and other materials supplied by the corporation to the SEC in connection with its registration statements, as well as all other presentations.

Calculations, and any other material relevant to this corporation in this matter.

Thank you, Mr. Chairman.

Mr. CHUMBRIS. Thank you, Mr. Chairman. I don't have many questions. I interjected several times to cover several points that I think needed to be covered at that particular time, but I think that one thing we ought to bear in mind is whether the type of insurance that you are providing to the public is one that is necessary because of the increased costs of hospitalization in this country which, as you pointed out, is \$192 a day in Philadelphia. It might be \$40 a day in some city in the State of North Carolina; or it may be \$116 a day, you may find, in Washington, D.C.

The question is whether the final coverage that the individual has can take care of that and, therefore, he may need supplemental insurance. And that's one point, the importance of supplementary insurance as far as the people of this country are concerned.

And, second, whether the people who provide that type of service are really providing the service that is advertised, that the people all believe that they are buying additional coverage.

In answer to many questions, you have related your side of the story as far as the advertisement seems to be much clearer than the content that appears to be in the policy itself. Well, maybe more people read the advertisement than read the policy, but I think the point the chairman made is one that maybe you want to consider in redrafting your policies so that it has the same clarity that the advertising does. Usually, it's the other way around. The advertising is one way and you think you are getting something and you don't look at the policy at all, and then you find out you are not covered. And I think that is of concern to any congressional committee and I am sure it is of concern to any company, if it is brought to their attention, because what you make this year you may lose the next 10 years if the public feels that you are not giving them what you are bargaining to give them.

Mr. SLATER. We will be very happy—and I think it is a fair criticism and we should review the particular policy forms to make sure the wording is as explicit and clear as we can possibly make it.

You mentioned Philadelphia with \$192. The fact is that the average policyholder lives in a town that has 10,000, 25,000 population so that it is something that people in the relatively small towns are interested in as well as in the big cities.

And the facts are that there are no coverages that just say they will take care of everything.

Mr. CHUMBRIS. That's right. We realize that. Even medicare itself pays—the Government itself realizes that they are not going to pay 100 percent of the claim and they pay 90 percent. On 90 percent, let us say, some of the testimony comes up they might end up by only paying 81 percent of the total cost of that particular expense that the particular patient has had.

Mr. SLATER. We have tried to take care of that difference between the 81 and the 100 percent.

Mr. CHUMBRIS. Now, the main point that I think the subcommittee is interested in is to make sure that your company and other companies, that do the same type of business that you do, will make sure that when a person is paying his premiums and he has this bill presented to him, he will get enough out of it to make up as much of the remaining difference as possible.

Mr. SLATER. This is what we believe that we are doing and, hopefully, we will make improvements as we go along. As you know, in the health care business, in 1970, there was some 25 million—25 billion—that was uncovered by either government or insurance, and it is in this area that we are trying to work.

Mr. CHUMBRIS. Sometimes it is unfair to a company like yours, which here before us, and everything is made public and you are doing something that is serving a purpose and perhaps some because of some inconsistencies, that are really trade practices you are given adverse reaction because of the testimony.

Whereas, people are really not careful in examining not only the advertising but the policy that they are buying.

Mr. SLATER. That is right.

Mr. CHUMBRIS. And that is a job for the insurance commissioners of each State to examine, as they all are, these different companies that come into their State to sell insurance.

Mr. SLATER. We did file, at the end of our long report, a comparison. Comparative figures of our premiums and benefits with 10 other companies.

Mr. CHUMBRIS. Yes, I noticed that in your statement.

Mr. SLATER. We are the largest in this particular field and we believe we are giving more benefits for lower premiums than anyone else.

Mr. CHUMBRIS. That is all I have, Mr. Chairman.

Mr. KERN. I have one question relating to the advertising brochure which we have been looking at earlier. Mr. Linkletter's endorsement. On page 4 of this, you state that you plan to pay up to \$400 a month cash for a registered nurse at home.

How comforting it is to know that after your stay in the hospital, if you have been there 5 days or more, for which you received benefits, you can return home to recoup and get—yet not be a burden to your loved ones.

And it goes on giving details. "If your doctor has you employ a full-time resident nurse, after you come home, it will pay you benefits up to \$400 a month, while you are continuously confined at home. And your benefits continue for the same number of days covered during the hospital, even up to 12 full months.

Doesn't this suggest to you, or wouldn't it mean that it might suggest to the person who reads this brochure that the \$400 a month would take care of the expense of a registered nurse? When you say that you can return home to recuperate and yet not be a burden to your loved ones?

Mr. SLATER. Well, I suppose you can take that kind of an interpretation out of it. The thought that was intended to get across was that by supplying \$400 a month you are going a long way to help pay this

cost, and the family can take care of some of it. But here is an additional sum of money to take care of that particular thing.

I might say, for your information, that we have just changed our policy so that we will take an LPN as well as a registered nurse.

Mr. KERN. Would this be a little clearer, perhaps, if you phrased this in terms of \$400 a month, not for a registered nurse at home, but to supplement the expense of a registered nurse.

I notice some of these other statements here you make a good deal clearer that this is a supplemental benefit. That is essentially goes on top of your maternity benefits and so forth.

But in the case of this registered nurse, I think the indication is perhaps a little stronger than perhaps you intended it.

Mr. SLATER. I don't want to sound the least bit facetious, but we have 51 jurisdictions already telling us how to write this particular clause and we are trying to get the best one, the one that is the most explicit, and we will take the one that you have given us and add it to it and come out, hopefully, with the best one there is.

We are changing our advertising copy and hopefully making it much more explicit and these things evolve with the years. They are a lot better today than they were a year ago, and next year I hope that the advertising copy is going to be better.

I do want to point out to you that in most states, his advertising copy is approved by the insurance department before it ever gets to the newspapers. And we have that ad checked, which you do not have in other kinds of insurance.

The agent goes out and, hopefully, he does not go off the beaten path in what he is supposed to say, but the only communication we have with the policyholders is that piece in the newspapers and it is approved by the insurance department before it ever gets to the newspapers.

Mr. KERN. I think that we are all just trying to insure that the purchaser of the insurance gets a clear picture.

Mr. SLATER. We have that same desire.

Mr. KERN. Thank you.

Senator HART. You told us that you do not understand your own automobile insurance coverage. Why is that?

Mr. SLATER. Well, have you ever read an automobile insurance policy?

Senator HART. Aren't they approved by a State insurance departments?

Mr. SLATER. That is correct, but I still——

Senator HART. So the appropriate insurance department does not inform you, and you are an actuary, how, in God's name, is Joe what's-his-name going to find out?

Mr. SLATER. We are not selling automobile insurance policies.

Senator HART. Do you think that is really responsive to the problem?

Mr. SLATER. I think you will find this, Senator, that in insurance policies, which have strong requirements to put in the precise words that the courts have determined are allowed, and if you try to deviate from those words, you run into problems.

When you come up with a claim, you establish whole new laws, as far as policies and interpretation of certain words is concerned, and

the result is that you are confined to a certain set of words because of the common law and other things that we have in present cases and other things that you cannot deviate from.

But I know that homeowner policies and automobile policies I think they are the two that are much more difficult to understand and I think that the basic reason for it is that the courts have established that these words mean these things and the companies have to put those words in their policies.

Senator HART. Well, that would follow that the kind of insurance you write is subject to no restraint and that you would have complete elbow room to make very explicit and understandable what you are offering.

Mr. SLATER. To a degree, sir. I do not know that we have as much freedom as we would like.

Senator HART. Well, as my question indicated, I was struck by the fact—and I am not suggesting that you are other than absolutely truthful—that you said you did not understand what your automobile insurance covers. It occurred to me that if someone is familiar with the area of insurance as you, found himself in that position, that it would underscore and dramatize the higher responsibility that every insurance company has to make clear its offer.

You know that you are writing for an audience that numbers many more nonactuaries than actuaries, nonlawyers than lawyers. A couple of lawyers have read your 2-year clause and we both admitted we did not understand what that means.

And you do not understand your automobile insurance policy. Small wonder that there may be a great many people who hope to God that they have got some coverage, but if their life depended on it—whether it is auto, house, or life—they could not tell you what it was.

Mr. SLATER. I think, sir, that the majority of American people do not understand their insurance policies. This may be that we have never taken the time to really look at them.

You buy an automobile insurance policy; you talk to the agent and whoever you do business with; and you take his explanation to you of what is in that policy when you get it.

I think this is generally true. And I think legal documents, whether they are deeds or wills or anything else, are such that they are rather difficult to understand.

Senator HART. Would you find life more bearable if you had only one insurance department to deal with than the 51 you mentioned periodically?

Mr. SLATER. In some respects, yes, sir. In other respects, no. Now, if you want the "no" part of it, if you have 51 States, you have to have 51 people disagree with you to put you out of business; but if you have one, and only one man can put you out of business in the whole country. So there are some disadvantages to Federal regulations.

But I think in the main, the answer is "Yes." We would rather have the one than the 51.

Mr. CHUMBRIS. I think you pleased the Senator with that last answer.

Senator HART. What was the rationale which persuaded you to purchase particular automobile insurance that you now have?

Mr. SLATER. You are talking about me, me personally?

Senator HART. I am talking about that policy you do not quite understand. Why did you buy it?

Mr. SLATER. If we are going to be real precise, I do not have an automobile. It is my wife's that I was talking about. The car I drive happens to be a rented one.

But the answer is that the particular automobile insurance company that we bought the insurance with, we have been doing business with that company for the last 25 years and we have always gotten good service, and we have dealt with them.

When something happens, we call the agent. The agent tells us whether it is covered or it is not covered.

Senator HART. That describes, I suppose, most of us. Satisfactory business for 25 years, but we do not quite know what the coverage was for 25 years, and that is a heck of a note, really. We should not joke about it, it is—

Mr. SLATER. I think it is so. And, on the other hand, I think, Senator, that our advertising copy is much more explicit than the policy, and that is made part of the policy.

Senator HART. Thank you very much.

Mr. CHUMBRIS. Before I leave the record, I want to say I talked about the Senator being happy with your statement. There are some of us on this committee who are unhappy with that statement.

(Documents relating to Mr. Slater's testimony follow. Testimony resumes on p. —.)

NATIONAL LIBERTY CORPORATION,
Valley Forge, Pa., July 5, 1972.

Re June 6, 1972 Hearing

SENATE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY,
Senate Annex,
Washington, D.C.

GENTLEMEN: During the course of our appearance before the Senate Antitrust and Monopoly Subcommittee on Tuesday, June 6, 1972, the Committee undertook to hold open the record to receive certain information discussed below. We herewith submit that information for the record.

1. Pre-Existing Condition Exclusion. During a somewhat extended colloquy with Senator Hart (N.T. 477-479), we agreed to furnish to the Subcommittee representative samples of explanatory statements in advertising copy and fulfillment material which describe in terms understandable to holders of our NH 10 Hospital Indemnity policies the pre-existing condition exclusion provision found in that policy.

The fulfillment materials are furnished to all purchasers of NH 10 policies during the period when they are entitled to have their premiums refunded if after review they are not satisfied with their policies. Our fulfillment material includes the statement quoted below which is designed to explain the pre-existing condition exclusion provision in the NH 10 policy in terms understandable to the average policyholder.

"What is not covered by this policy? The only conditions not covered are . . . any sickness or injury you had before the Policy Effective Date (during the first two years only)."

Included in the application form to be signed by NH 10 policyholders is the following statement which has been designed recently to explain the pre-existing condition exclusion in terms understandable to the average policyholders.

"I hereby enroll in the National Home Health Plan and am enclosing the first month's premium to cover myself and any other person(s) listed above. I understand that this Policy will become effective when issued, pre-existing conditions will be covered after two years and new conditions will be covered immediately."

An example of current advertising copy which is similarly designed to make clear to prospective policyholders the meaning of the pre-existing condition exclusion provision is as follows:

"These are the only exclusions. Your National Home policy covers every kind of sickness or accident except conditions caused by :

1. Any sickness or injury which existed before the policy went into effect (all pre-existing conditions are covered after policy has been in force for two years)."

We will continue our efforts to improve our advertising copy, fulfillment material and policy forms so that no prospective policyholder will have any doubts with respect to the effect of the pre-existing conditions exclusion provisions in our policies.

2. Lapse Rates. At pages 502 and 503 of the notes of testimony there is reproduced colloquy between me and Mr. Sharp relating to discrepancies between lapse data filed with the S.E.C. and that filed with the State Insurance Departments. The explanations of these discrepancies is described in the enclosed memorandum dated June 22, 1972, marked for identification purposes as Exhibit "A", and already furnished to the S.E.C. at its request.

3. Profit Margins. At pages 503 through 506 of the notes of testimony there is reproduced colloquy between me and Mr. Sharp relating to the apparently high profit margins projected in a schedule filed with the S.E.C. As shown in our annual reports filed for calendar years 1970 and 1971 (already made a part of the record) the National Liberty Group's operating profit in respect of its insurance operations represented approximately 16% and 18% of its premium income in each of those years, respectively. As discussed below, then, the schedule referred to by Mr. Sharp as showing projections of profits as a percentage of premiums filed with the S.E.C., are totally out of line with what in fact has happened and will happen.

The schedule referred to was an attachment to a letter dated July 27, 1971 from Norman E. Hill, an actuary with Peat, Marwick and Mitchell Company. This schedule was prepared by Mr. Hill in response to a specific question raised by the S.E.C. as to what tests had been made to assure the recoverability of deferred policy acquisition costs incurred by the National Liberty Group in marketing its mass merchandised accident and health policies. The test was made for the sole purpose of determining whether, using the most conservative financial and actuarial assumptions, the recoverability of acquisition costs would be assured. The schedule was not intended to project a profit margin for the NH 10 policy, and in fact, does not do so as stated above. The figures from the schedule cited by Mr. Sharp (pages 503 and 504 in notes of testimony) as margins of profit as a percent of premium for NH 10 policies range from 34.7% to 46.4%. In determining the percentages referred to above, several factors necessary to develop profit projections were ignored. The most obvious of these factors were:

a. The schedule assumed acquisition costs of 50% for the first policy year and 20% for each policy year thereafter. These acquisition costs were assumed for the purpose of showing the margin to the issuing insurance company (without regard to other acquisition costs borne by members of the group other than the insurance company). In fact, the acquisition costs for the business borne by all members of the group were higher than the 50-20 rates assumed, and on that same schedule there were shown acquisition costs more closely related to those actually incurred. The "profit margins" scheduled on the basis of these latter assumptions were lower than those quoted by Mr. Sharp.

b. The "profit margins" shown on the schedule were before expenses for maintaining the business including billing, collecting, and processing of premium, claims and general administration costs, income taxes and premium taxes.

c. The schedule was prepared on the basis of persistency assumptions which have subsequently proved to be somewhat too high on the basis of lapse data which became available to the Company after the schedule was prepared.

Summary. We are proud of the fact that the National Liberty Group is able to earn a profit in its accident and health insurance operations. We are of the view that this profit is made possible by the facts that we offer to the public at fair prices products which are needed, and that we have been able to effect substantial economies and efficiencies in our operations. Our profits are not earned at the expense of our policyholders as demonstrated by the fact that our policies give better coverage at lower cost than do the policies of our competitors. See the comparative rates and benefits study made a part of the record and referred to at pages 18 and 19 of our written submission to the Subcommittee. Further, our profits can not be characterized as exorbitant in view of the facts that they represent a return for performing two functions (marketing and underwriting), and that the business is relatively new which justifies a relatively higher return because of the increased risks involved.

4. Advertising. On pages 510 through 514 of the notes of testimony is reproduced colloquy between Mr. Sharp and me relating to the regulation by the State Insurance Departments of the advertising practices of the National Liberty Group. We undertook to submit for the record a memorandum showing our current regulatory status with the State Insurance Departments. We attach the said memorandum marked as Exhibit "B" for identification.

Respectfully submitted.

NATIONAL LIBERTY CORPORATION,
ROBERT E. SLATER, *Chairman*.

EXHIBIT A

NATIONAL LIBERTY CORPORATION

USE OF PERSISTENCY DATA FOR FINANCIAL REPORTING AND PREMIUM RATE-MAKING

This memorandum has been prepared by National Liberty Corporation ("NLC") at the request of Mr. Barry Thorpe, a member of the staff of the Securities and Exchange Commission. Mr. Thorpe has asked whether there is any difference between the persistency data used by NLC for financial reporting purposes and for premium rate-making purposes and the reasons for any such difference.

DEFINITION OF PERSISTENCY

As used in this memorandum, "persistency" refers to the actuarially calculated likelihood that insurance policies in force at the beginning of a policy year will continue in force through the end of that year. The number representing the expected percentage of policies that will continue in force is called the "persistency rate." This rate is referred to in the Company's filings with state regulatory authorities. The "lapse rate", referred to in the Company's Prospectus dated August 26, 1971 (hereafter referred to as the "Prospectus"), is the counterpart of the persistency rate. Stating the rate in terms of "lapse" rather than "persistency" may tend to have a somewhat more cautionary impact on investors and was thus deemed appropriate for use in the Prospectus.

USE OF PERSISTENCY RATES

1. Premium Rates. Persistency rates are one factor considered in setting premiums to be charged for policies. Among other factors relevant to the determination of premium rates are claim costs, general overhead expenses, premium taxes, acquisition costs and contingencies. Assumptions with respect to these factors (in addition to persistency assumptions) are considered by State regulatory authorities in the course of their review of rate filings.

If, for example, a policy is expected to persist in force for a relatively short period of time, it would ordinarily be appropriate to charge a higher premium because the cost of obtaining policies (the acquisition cost) is relatively constant and is higher than the cost of maintaining the policies, and this acquisition cost would have to be recovered over a shorter period of time through relatively higher premiums. In state rate filings persistency rates are calculated for various age bands since premium rates vary for each age group. A composite or weighted average persistency rate, encompassing all age bands, is used for financial reporting. In this memorandum, age band 50-54 is used since, as stated on page 14 of the Prospectus, at December 31, 1970, the average age of a person when he purchased National Liberty Corporation's accident and health insurance was 52, and therefore this is thought to be the most typical age band. A copy of the form of state filing made by National Liberty Corporation since 1969 for direct response, broad market accident and health insurance policies (NH 10) is attached to this memorandum as Exhibit A.

CALCULATION OF PERSISTENCY RATES

Persistency rates are essentially projections of events that have not yet occurred—the renewal or lapsation of insurance policies by policyholders. In that sense, they are similar to other kinds of rates used for financial reporting and other purposes that are essentially predictions—for example, depreciation rates that assume the useful life of certain assets. While all persistency rates for insurance companies involve projections, the assumptions underlying those projec-

tions may vary from company to company. The particular company's past experience is of course an important guide to its projected persistency rates. But experience is not the only guide, especially when, as in NLC's case, the experience may be relatively limited or may be changing as a result of the introduction of new types of insurance and changes in marketing methods. Accordingly, a company's actual experience must be supplemented by the use of standard actuarial techniques in establishing persistency rates. NLC has been assisted by its independent auditors, Lybrand, Ross Bros. & Montgomery and Peat, Marwick, Mitchell & Co., and their actuarial divisions in the development of its persistency rates for financial reporting.

1. Comparison of Persistency Rates. The table below shows NLC's persistency rate assumptions used in (1) financial statements for the year ended December 31, 1970 (included in the Prospectus), (2) financial statements for the year ended December 31, 1971 (included in NLC's Form 10-K and in its Annual Report to Shareholders for that period) and (3) state rate filings for NLC's NH 10 (direct response, broad market) hospital indemnity policy since 1969.

Policy year	Dec. 31, 1970	Dec. 31, 1971	State filings ¹	Policy year	Dec. 31, 1970	Dec. 31, 1971	State filings ¹
1.....	79.2	75.4	75.7	11.....	28.8	22.9	17.5
2.....	61.7	55.4	57.8	12.....	27.4	21.1	15.4
3.....	49.9	47.5	46.7	13.....	26.1	19.4	13.6
4.....	42.6	41.7	39.6	14.....	24.7	17.8	11.9
5.....	38.5	37.2	34.2	15.....	23.3	16.4	10.5
6.....	36.3	35.3	31.7	16.....	22.0	15.1	9.1
7.....	34.4	32.1	28.2	17.....	20.6	13.9	7.9
8.....	32.7	29.5	25.1	18.....	19.2	12.8	6.9
9.....	31.3	27.1	22.3	19.....	17.8	11.8	6.0
10.....	30.0	24.9	19.9	20.....	16.4	10.9	5.2

¹ Age band 50-54.

2. Financial Reporting. As stated on pages 6-7 of the Prospectus, NLC calculated the persistency rates used in the 1970 financial statements on the basis of the Linton B table (a standard actuarial table) as modified (a), to include a mortality factor, and (b) to reflect the Company's actual experience for the first five years. Meaningful statistics on actual experience beyond five years were not then available. The table on page 6 of the Prospectus showed that NLC's persistency experience for the first five years was worse than the Linton B calculation. As set forth in a letter dated June 4, 1971 from NLC's auditors to the Commission, the Linton B table does not reflect a mortality factor, although the data showing the Company's experience did reflect that factor.¹ Had the Linton B table been adjusted to reflect mortality, comparison with the Company's actual experience would have been more favorable than shown in the Prospectus.

NLC pointed out on page 7 of the Prospectus that:

(1) the modification of the Linton B table to reflect actual experience resulted in a more rapid amortization of policy acquisition costs (and thus lower income) than would have been the case had Linton B alone been used, and

(2) the amortization schedule would be modified if future experience showed that persistency assumptions should be modified.

As NLC advised its shareholders in its 1971 Annual Report, page 27 of which is attached to this memorandum as Exhibit B, a new computer program developed in late 1971 enabled the Company to obtain persistency data based on actual experience for 12 years—that is, since the Company's inception. These data resulted in some modifications in the persistency assumptions previously used, particularly after the first six policy years. The newly developed data were utilized in the Company's 1971 financial statements. While the differences between the persistency rates used in 1970 and those used in 1971 are greater in later policy years, the number of policies to which the rates in those later years is applied is relatively small and therefore the impact of the differences on

¹ Mortality—the likelihood of death of a policyholder—is one reason for the lapse of a policy. This is to be distinguished from morbidity, a term which refers to the likelihood of a claim by a policyholder. Morbidity has no bearing on persistency; it does affect a company's premiums/claims (or loss) ratio.

income is also relatively small. After the twentieth year, all remaining acquisition costs are written off.

3. State filings. As the table above shows, there are some differences between persistency rates used for financial reporting and those used for state filings. However, these data are not comparable, and, in fact, it would be coincidence only if the persistency assumptions used were the same for both purposes. Financial reporting projects expected earnings in respect of a book of business already in existence when the projections are made. Rate filings, however, are made for business which will be written in the future. To the extent that past and future business have different characteristics (different types of markets, different age mixes, etc.,) which would likely affect persistency, there are differences in persistency assumptions as would be expected.

For financial reporting a composite set of persistency data for all age bands is used, whereas for state rate filings separate sets of data for each age band are used. As noted previously, we have used age band 50-54 in the table for comparative purposes since the average age of a new policyholder (as of December 31, 1970) was 52.

The major portion of all policies sold since 1968 has been to the "broad market" whereas prior to that time virtually all were to the "abstainer market". Our experience has shown that policies sold to the abstainer market have a higher persistency rate than do those sold to the broad market. Therefore, the persistency assumptions used in rate filings (all broad market) are lower than are those used for financial reporting purposes. This is because the book of business generating the income stream projected for financial reporting purposes includes a composite of all types of policies at various age bands and includes not only broad market policies but also abstainer policies with higher persistency rates, whereas the books of business on which the rate filings are based are comprised solely of broad market policies with lower persistency assumptions at specific age bands.

Furthermore, the persistency assumptions used in rate filings cannot effectively be "updated". The insurance in question is guaranteed renewable, and there can be no assurance that state authorities would allow higher premiums in the future to offset lower persistency experience. In that regard, NLC has not materially altered its persistency assumptions for state rate filings since 1969, although the assumptions for financial reporting were changed at year-end 1971.

The more substantial differences between the rates used for state filings and those used for financial reporting occur in later policy years where, as noted earlier, the number of policies to which the rates are applied is relatively small and the effect on income is therefore also relatively small.

CONCLUSION

A review of persistency rates used for financial reporting and state filings indicates that:

1. The standard actuarial rates produced by the Linton B table would have been unduly favorable and were therefore appropriately adjusted for the 1970 financials on the basis of NLC's actual experience for five years.

2. When additional information about NLC's actual experience for 12 years, including experience for 1971, became available, persistency rates were appropriately adjusted to reflect the new data in the 1971 financials. However, the effect of the adjustment was relatively small because it related primarily to the later policy years.

3. While some differences exist between persistency rates used for financial reporting and for state filings, the two sets of rates are not comparable for the reasons discussed above. Also, (a) these differences occur primarily with respect to later policy years when the number of policies to which the rates apply is relatively small and the impact on NLC earnings is therefore also relatively small, and (b) the state filings relate solely to specific broad market policies, with somewhat lower persistency assumptions.

4. As the Company continues to accumulate experience, including additional experience with broad market insurance, the Company will continue to compare its persistency assumptions with its actual experience, and it will modify the persistency assumptions if necessary. This is precisely what the Company undertook to do on page 7 of the Prospectus.

JUNE 22, 1972.

EXHIBIT B

REGULATORY STATUS OF NATIONAL HOME LIFE ASSURANCE COMPANY

JULY 5, 1972.

There follows a brief description of regulatory questions pending with state Insurance Departments at June 2, 1972, primarily concerning advertising, and the current status of those regulatory matters.

California. Since June 2, 1972, T.V. advertising, a free fall insert and a direct mail kit have been accepted and we have been allowed to resume advertising in California. Technically, however, a formal proceeding is still pending, and a hearing is scheduled for July 24th.

Florida. A proceeding relating to advertising is still pending, but negotiations for its termination are underway, new advertising is being submitted, and we hope that the matter will be closed without the necessity of a formal hearing. The hearing has been rescheduled for August 9th.

Indiana. New advertising guidelines were promulgated May 10, 1972. Ads were developed and submitted based upon these new guidelines, and we expect the Department to advise us today whether further revisions will be necessary.

Maryland. The Department has requested us to submit all advertising for prior approval. Ads are being developed for submission.

Michigan. Discontinuance of ads containing Art Linkletter was requested as of May 20, 1972, and we have discontinued all advertising. Revised ads have been submitted for review.

Minnesota. A formal proceeding has been terminated by stipulation and revised advertising has been submitted for approval in accordance with its terms.

Nevada. The Company and its advertising was criticized in a letter from the Commissioner to Arthur Linkletter, a Director, stockholder and marketing consultant to the Company. The Company requested a conference at which it was learned that the Department's views were such that a complete revision of both policies and advertising would be required.

The Company hopes to comply and in due course will submit policies and advertising for approval. In the interim, at the request of the Nevada Commissioner, all activities except servicing of existing policies have been terminated.

New Mexico. The Company has been requested to pay a rejected claim and to submit advertising materials. We anticipate renewal of our license when this has been done.

North Carolina. Several conferences have been held with the Department relating to the statutory losses that have resulted in the past from our large expenditures for the acquisition of new business.

Beginning April 1, 1972 most of the solicitation costs of the Group will be expended outside the insurance companies, thus eliminating statutory losses. As the result of this change in marketing procedures, it is estimated that the \$5,000,000 loss for the first quarter will be eliminated and that the Company will have a statutory gain of approximately \$500,000 for the first six months of 1972. We also contemplate a capital and surplus of a minimum of \$5,000,000 as of June 30, 1972, increasing at the rate of at least \$250,000 per quarter over that amount thereafter.

Ohio. A public hearing on proposed advertising regulations was held June 29, 1972. When the regulations are officially adopted ads will be submitted for approval.

Oklahoma. A proceeding has been terminated by stipulation, and new ads have been found acceptable.

Pennsylvania. The company is free to advertise so long as it complies with existing advertising and fair trade regulations. However, since new regulations have been pending for some months, the Company has chosen to hold up solicitations rather than incur printing costs which might be lost if the advertising did not comply with the new guidelines.

Texas. Proceedings have been terminated. New advertising has been submitted. Our major ad, a hospital, free fall, has been found acceptable.

Vermont. The Department has suggested specific ad copy changes, including those with respect to the use of Arthur Linkletter. Ads are being developed which it is believed will conform to these requirements.

Washington. Questions raised by the Department have been resolved. An ad submitted to the Department has been accepted.

West Virginia. The Company was originally requested to cease solicitations in a letter relating to resident agent procedures. These were corrected, but the hold has continued because of concerns over our previous acquisition-cost-created statutory losses. The Company believes this situation will be cleared up following the submission of our six months statement and the Examination Report completed in draft form on June 2, 1972.

Wyoming. A cease and desist was issued primarily because of the inadvertent use of an ad containing an objectionable endorsement contrary to a representation made some months before. A fine of \$2,000 has been imposed together with a ninety day suspension until September 1, 1972. The Company has requested that the proceeding be reopened and the penalties mitigated.

The Company continues to receive from day to day requests to revise specific ads and notifications that certain ads may not meet the requirements of proposed or new guidelines. In such cases revised ads are prepared and submitted for review to be certain they comply with the suggested revisions.

Every effort is always made to comply promptly and completely with such notifications. In some instances, advertising may be discontinued until we are certain it complies.

NATIONAL LIBERTY CORPORATION.

NATIONAL HOME LIFE ASSURANCE COMPANY

An Old Line Legal Reserve Company of St. Louis, Missouri

ADMINISTRATIVE OFFICE: VALLEY FORGE, PENNSYLVANIA

Extra Cash Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your", or "yours," and the National Home Life Assurance Company will be referred to as "we," "our," or "us."

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided.

CONSIDERATION

This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule and with the qualification that, to the best of your knowledge and belief, no Covered Member has been refused any health, hospital, or life insurance coverage due to reasons of health. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium has been paid in advance of the Effective Date. (The postmark on the envelope containing your payment shall be considered the date of payment.)

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 15 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE TABLE OF PREMIUM RATES

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment, in advance, within the Grace Period, of the renewal premium at our premium rate in effect for all policies and classes of policyholders in this series, NH-10-669, in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies or such classes of policyholders in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

PRE-EXISTING CONDITIONS

After 2 years from the date this Policy becomes effective for a Covered Member hospital confinement commencing thereafter while this Policy is in force for such Covered Member and as a result of any condition for which such Covered Member was medically treated or advised prior to the Effective Date, shall be covered hereunder. (See Uniform Provision entitled "Time Limit On Certain Defenses.")

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

- If such member is under age 65 (but not an unmarried dependent child) at the time hospital confinement commences, we will pay the Monthly Indemnity shown in the Policy Schedule.
- If such member is age 65 or over at the time hospital confinement commences, we will pay 50% of the Monthly Indemnity shown in the Policy Schedule during the first 3 months of such covered confinement. If such confinement continues for more than 3 months, the full Monthly Indemnity shown in the Policy Schedule will be paid during such continuous confinement beginning with the 4th month.
- If such member is an unmarried dependent child, between the ages of 1 month and 19 years, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions" set forth below. For periods of hospital confinement of less than one full month a proportionate payment will be made.

MATERNITY BENEFIT: If the Maternity Benefit is provided as specified in the Policy Schedule, or by endorsement, and by reason of pregnancy, childbirth, or miscarriage, the Covered Wife is confined to a hospital, we will pay you as the rate of the Monthly Indemnity shown in the Policy Schedule, beginning with the first day and continuing for the period of such confinement subject to the requirements that both Husband and Wife are insured under this Policy at the time hospital

confinement commences and during the entire period of pregnancy. However, coverage for the Covered Husband shall be required only at the time of conception in the event of his death or entry into the Armed Services.

NEWBORN CHILDREN: If this Policy provides coverage for unmarried dependent children between the ages of 1 month and 19 years as specified in the Policy Schedule, a child born to you and your spouse while this Policy is in force will automatically become a Covered Member at the age of 1 month. No additional premium charge will be made.

DISMEMBERMENT BENEFIT: When accidental bodily injury to a Covered Member results, within 90 days from the date of the accident causing such injury, in any of the losses specified below, we will pay you the sum set opposite the specific loss. In the event of more than one loss only one sum will be paid, the larger. Payment made under this provision shall be in addition to any other benefits payable under this Policy.

For injury resulting in loss of:

Both hands or both feet or the sight of both eyes	\$2,000.00
One hand and one foot	\$2,000.00
One hand or one foot and sight of one eye	\$2,000.00
One hand or one foot or sight of one eye	\$1,000.00

Loss of hand or foot means severance at or above the wrist or ankle joint.

Loss of sight must be entire and irrecoverable.

SIMULTANEOUS CONFINEMENT BENEFIT: If Husband and Wife are simultaneously confined in a hospital because of injury, and while both are covered under this policy, the applicable Monthly Indemnity for hospital confinement for each will be doubled during the actual period of time that both are simultaneously confined.

REGISTERED NURSE AT HOME BENEFIT: When by reason of injury or sickness a Covered Member is continuously confined at home immediately following a period of hospital confinement of 5 consecutive days or more and for which benefits were paid under the Monthly Hospital Benefit provision, and the services of a registered nurse are employed under the direction of the attending physician and expenses for employment of such nurse are actually incurred by you, we will pay at the rate of \$400 per month for a period not to exceed the period of preceding hospital confinement and, in no event, to exceed 12 months for any one injury or sickness subject to the following limitations:

- Such nurse must be employed within 5 days following the immediately preceding period of hospital confinement.
- Such nurse shall perform not less than one full shift on any day or days such nursing care is required.
- No benefit shall be paid for nursing services rendered more than 14 months after the immediately preceding period of covered hospital confinement.

For periods of covered Registered Nurse At Home expenses of less than one full month, a proportionate payment will be made.

WAIVER OF PREMIUM PROVISION

After you have been confined in the hospital for 8 consecutive weeks while this Policy is in force and while benefits are payable under this Policy for such confinement, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment of premiums by you. After termination of such hospital confinement for which the premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy. This provision shall apply only if you (the Insured) are so confined.

TERMINATION

A covered dependent child shall cease to be covered upon his marriage, cessation of his dependency on you, or on his 19th birthday; (subject, however, to the Conversion Privilege provision), except that his coverage under this Policy shall not terminate at age 19 if he is incapable of self support due to mental retardation or physical handicap and is dependent upon you for support and maintenance, providing you furnish satisfactory proof of his incapacity to us within 31 days of his 19th birthday and you continue to pay the required premium. Beginning with such child's 19th birthday the Monthly Indemnity Benefit payable for confinement will increase to the full amount listed in the Policy Schedule and the premium required will be that amount applicable to his attained age. Such child shall continue to be eligible for as long as such incapacity continues.

If we accept a premium on account of any covered dependent child which would continue coverage beyond the date of termination described above, coverage for such dependent child shall be extended for the period to which such premium applies.

CONVERSION PRIVILEGE

We will issue to any Covered Member who attains the age of 19, is married prior thereto or who ceases to be dependent on you while this Policy is in force, if he so elects by written notice to us mailed within 31 days after he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided under this Policy and at the premium rate for his attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses," will be the date such Covered Member was originally insured under this Policy. No benefits will be payable under such policy, however, for any injury or sickness for which benefits were payable under this Policy.

DEFINITIONS

"Covered Member" means you or any family member named in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children between the ages of 1 month and 19 years and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission of proper application.

"Sickness" means sickness or disease which is first manifested after the Effective Date of this Policy and while this Policy is in force.

"Injury" means accidental bodily injury sustained, directly and independently of all other causes, on or after the Effective Date of this Policy and while this Policy is in force.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is not immediately related to you.

"Nurse" means a graduate, Registered Nurse, (R.N.), who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis; and which maintains facilities for medical diagnosis and treatment of such persons by or under the supervision of a staff of physicians; and which provides 24 hour a day nursing service by and under the supervision of registered nurses; and which provides facilities for major surgery; and which is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculosis sanatorium and/or hospital, or a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility owned or operated by the United States government or any of its agencies which does not require payment for its services.

"Resident Patient" means one who is confined to a Hospital and for whom a charge is made by the Hospital for each day so confined. This does not include one whose confinement is not necessary for medical treatment or who is occupying any form of rest, nursing, convalescent, rehabilitation or extended care facility.

"Continuously Confined At Home" means necessary and continuous confinement at home, under the care of a physician, which shall not be terminated by reason of necessary visits to the doctor's office or hospital and/or sitting in the sunshine upon the recommendation of your doctor.

RECURRENT CONDITIONS

After benefits have become payable under this Policy for any condition, if subsequent expenses are incurred for the same or a related condition or conditions, such expenses shall be regarded as incurred for the same injury or sickness unless separated by a continuous period of 90 days during which time the person incurring such expense has resumed full normal activities, in which case the subsequent expenses will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

EXCLUSIONS

We will not pay benefits for any loss caused by or contributed to by: (1) War or any act of war; (2) Pregnancy, except if provided under the Maternity Benefit provision; (3) Any mental disease or disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, together with any endorsements and papers, constitute the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: (a) After 2 years from the Effective Date of this Policy no statements except fraudulent misstatements, made by you in the application for this Policy shall be used to void this Policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period. (b) No claim for loss incurred commencing after 2 years from the Effective Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description had existed prior to the Effective Date of this Policy.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY: If this Policy has lapsed, a subsequent acceptance of a premium by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy, provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such application unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the due date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to us, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS: Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS: Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you during your lifetime. Any accrued benefits unpaid at your death will be paid to your beneficiary, or in the absence of a named beneficiary, to your estate except that, at our option, we may pay any such accrued benefits, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS: At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

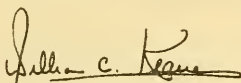
UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.


PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.

OTHER INSURANCE IN OUR COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

CLERICAL ERROR: A clerical error by us shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our President and Secretary.


William C. Keane
Secretary


T. Robert Wilcox
President

Countersignature of licensed resident agent if required by your state.

Extra Cash
Hospitalization
Indemnity Plan

NH 10-669

NATIONAL HOME
LIFE ASSURANCE
COMPANY
An Old Line Legal Reserve Company
of St. Louis, Missouri
ADMINISTRATIVE OFFICE
VALLEY FORGE, PENNSYLVANIA

NATIONAL HOME LIFE ASSURANCE COMPANY

An Old Line Legal Reserve Company of St. Louis, Missouri

ADMINISTRATIVE OFFICES: VALLEY FORGE, PENNSYLVANIA

Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your," or "yours," and the National Home Life Assurance Company will be referred to as "we," "our," or "us."

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided.

CONSIDERATION

This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium has been paid in advance of the Effective Date.

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 15 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE TABLE OF PREMIUM RATES

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment, in advance or within the Grace Period, of the renewal premium at our premium rate in effect for all policies and classes of policyholders in this series, NH-10-669 Pa., in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies or such classes of policyholders in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

PRE-EXISTING CONDITIONS

After 2 years from the date this Policy becomes effective for a Covered Member hospital confinement commencing thereafter while this Policy is in force for such Covered Member and as a result of any condition for which such Covered Member was medically treated or advised prior to the Effective Date, shall be covered hereunder. (See Uniform Provision entitled "Time Limit on Certain Defenses.")

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

- If such member is under age 65 (but not an unmarried dependent child) at the time hospital confinement commences, we will pay the Monthly Indemnity shown in the Policy Schedule.
- If such member is age 65 or over at the time hospital confinement commences, we will pay 50% of the Monthly Indemnity shown in the Policy Schedule during the first 3 months of such covered confinement. If such confinement continues for more than 3 months, the full Monthly Indemnity shown in the Policy Schedule will be paid during such continuous confinement beginning with the 4th month.
- If such member is an unmarried dependent child, between the ages of 1 month and 19 years, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions" set forth below. For periods of hospital confinement of less than one full month a proportionate payment will be made.

MATERNITY BENEFIT: If the Maternity Benefit is provided as specified in the Policy Schedule, or by endorsement, and by reason of pregnancy, childbirth, or miscarriage, the Covered Wife is confined to a hospital, we will pay you at the rate of the Monthly Indemnity shown in the Policy Schedule, beginning with the first day and continuing for the period of such confinement subject to the requirements that both Husband and Wife are insured under this Policy at the time hospital confinement commences and during the entire period of pregnancy. However, coverage for the Covered Husband shall be required only at the time of conception in the event of his death or entry into the Armed Services.

NEWBORN CHILDREN: If this Policy provides coverage for unmarried dependent children between the ages of 1 month and 19 years as specified in the Policy Schedule, a child born to you and your spouse while this Policy is in force will automatically become a Covered Member at the age of 1 month. No additional premium charge will be made.

DISMEMBERMENT BENEFIT: When accidental bodily injury to a Covered Member results, within 90 days from the date of the accident causing such injury, in any of the losses specified below, we will pay you the sum set opposite the specific loss. In the event of more than one loss only one sum will be paid, the larger. Payment made under this provision shall be in addition to any other benefits payable under this Policy.

For injury resulting in loss of:

Both hands or both feet or the sight of both eyes	\$2,000.00
One hand and one foot	\$2,000.00
One hand or one foot and sight of one eye	\$2,000.00
One hand or one foot or sight of one eye	\$1,000.00

Loss of hand or foot means severance at or above the wrist or ankle joint.

Loss of sight must be entire and irrecoverable.

SIMULTANEOUS CONFINEMENT BENEFIT: If Husband and Wife are simultaneously confined in a hospital because of injury, and while both are covered under this policy, the applicable Monthly Indemnity for hospital confinement for each will be doubled during the actual period of time that both are simultaneously confined.

REGISTERED NURSE AT HOME BENEFIT: When by reason of injury or sickness a Covered Member is continuously confined at home immediately following a period of hospital confinement of 5 consecutive days or more and for which benefits were paid under the Monthly Hospital Benefit provision, and the services of a registered nurse are employed under the direction of the attending physician and expenses for employment of such nurse are actually incurred by you, we will pay at the rate of \$400 per month for a period not to exceed the period of preceding hospital confinement and, in no event, to exceed 12 months for any one injury or sickness subject to the following limitations:

- Such nurse must be employed within 5 days following the immediately preceding period of hospital confinement.
- Such nurse shall perform not less than one full shift on any day or days such nursing care is required.
- No benefit shall be paid for nursing services rendered more than 14 months after the immediately preceding period of covered hospital confinement.

For periods of covered Registered Nurse At Home expenses of less than one full month, a proportionate payment will be made.

WAIVER OF PREMIUM PROVISION

After you have been confined in the hospital for 8 consecutive weeks while this Policy is in force and while benefits are payable under this Policy for such confinement, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment of premiums by you. After termination of such hospital confinement for which the premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy. This provision shall apply only if you (the Insured) are so confined.

TERMINATION

A covered dependent child shall cease to be covered upon his marriage, cessation of his dependency on you, or on his 19th birthday; (subject, however, to the Conversion Privilege provision), except that his coverage under this Policy shall not terminate at age 19 if he is incapable of self support due to mental retardation or physical handicap and is dependent upon you for support and maintenance, providing you furnish satisfactory proof of his incapacity to us within 31 days of his 19th birthday and you continue to pay the required premium. Beginning with such child's 19th birthday the Monthly Indemnity Benefit payable for confinement will increase to the full amount listed in the Policy Schedule and the premium required will be that amount applicable to his attained age. Such child shall continue to be eligible for as long as such incapacity continues.

If we accept a premium on account of any covered dependent child which would continue coverage beyond the date of termination described above, coverage for such dependent child shall be extended for the period to which such premium applies.

CONVERSION PRIVILEGE

We will issue to any Covered Member who attains the age of 19, is married prior thereto or who ceases to be dependent on you while this Policy is in force, if he so elects by written notice to us mailed within 31 days after he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided under this Policy and at the premium rate for his attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses," will be the date such Covered Member was originally insured under this Policy. Any loss incurred resulting from injury or sickness while this Policy is in force and for which benefits are payable under this Policy shall not be eligible for additional concurrent benefits under the converted policy, nor shall such loss restrict in any way benefits payable under the converted policy for loss incurred while that policy is in force.

DEFINITIONS

"Covered Member" means you or any family member named in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children between the ages of 1 month and 19 years and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission of proper notification.

"Sickness" means sickness or disease which is first manifested after the Effective Date of this Policy and while this Policy is in force.

"Injury" means accidental bodily injury sustained, directly and independently of all other causes, on or after the Effective Date of this Policy and while this Policy is in force.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is not immediately related to you.

"Nurse" means a graduate, Registered Nurse, (R.N.), who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis; and which maintains facilities for medical diagnosis and treatment of such persons, by or under the supervision of a staff of physicians; and which provides 24 hour a day nursing service by and under the supervision of

registered nurses; and which provides facilities for major surgery; and which is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculosis sanatorium and/or hospital, or a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility owned or operated by the United States government or any of its agencies which does not require payment for its services.

"Resident Patient" means one who is confined to a Hospital and for whom a charge is made by the Hospital for each day so confined. This does not include one whose confinement is not necessary for medical treatment or who is occupying any form of rest, nursing, convalescent, rehabilitation or extended care facility.

"Continuously Confined at Home" means necessary and continuous confinement at home, under the care of a physician. Such confinement shall not be considered terminated by reason of necessary visits to the doctor's office or hospital and/or sitting in the sunshine upon the recommendation of your doctor.

RECURRENT CONDITIONS

After benefits have become payable under this Policy for any condition, if subsequent expenses are incurred for the same or a related condition or conditions, such expenses shall be regarded as incurred for the same injury or sickness unless separated by a continuous period of 90 days during which time the person incurring such expense has resumed full normal activities, in which case the subsequent expenses will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

EXCLUSIONS

We will not pay benefits for any loss caused by or contributed to by: (1) War or any act of war; (2) Pregnancy, except if provided under the Maternity Benefit provision; (3) Any mental disease or disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy together with any endorsements and attached papers, if any, constitute the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred or disability commencing after 2 years from the Effective Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of this Policy.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY: If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of a premium by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy, provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the due date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS: Written notice of claim must be given to us within 30 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to our Administrative Offices, Valley Forge, Pennsylvania, Home Office, Saint Louis, Missouri, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIMS FORMS: Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS: Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you during your lifetime. If any benefit unpaid at your death shall be payable to your estate, or to your beneficiary who is a minor or otherwise not competent to give a valid release, we may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS: At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which, on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.

OTHER INSURANCE IN THIS COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

CLERICAL ERROR: A clerical error by us shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our President and Secretary.

William C. Keane

William C. Keane
Secretary

T. Robert Wilcox

T. Robert Wilcox
President

Countersignature of licensed resident agent if required by your state.

Hospitalization
Indemnity Plan

NH 10 669 PA.

NATIONAL HOME
LIFE ASSURANCE
COMPANY
An Old Line Legal Reserve Company
of St. Louis, Missouri
ADMINISTRATIVE OFFICES
VALLEY FORGE, PENNSYLVANIA

NATIONAL HOME LIFE ASSURANCE COMPANY

An Old Line Legal Reserve Company of St. Louis, Missouri

ADMINISTRATIVE OFFICE: VALLEY FORGE, PENNSYLVANIA

Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your," or "yours," and the National Home Life Assurance Company will be referred to as "we," "our," or "us."

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided.

CONSIDERATION

This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule and with the qualification that, to the best of your knowledge and belief, no Covered Member has been refused any health, hospital, or life insurance coverage due to reasons of health. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium has been paid in advance of the Effective Date. (The postmark on the envelope containing your payment shall be considered the date of payment.)

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 15 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE TABLE OF PREMIUM RATES

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment, in advance or within the Grace Period, of the renewal premium at our premium rate in effect for all policies and classes of policyholders in this series, NH-10-669 Mich., in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies or such classes of policyholders in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

PRE-EXISTING CONDITIONS

After 2 years from the date this Policy becomes effective for a Covered Member hospital confinement commencing thereafter while this Policy is in force for such Covered Member and as a result of any condition for which such Covered Member was medically treated or advised prior to the Effective Date, shall be covered hereunder. (See Uniform Provision entitled "Time Limit On Certain Defenses.")

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

- If such member is under age 65 (but not an unmarried dependent child) at the time hospital confinement commences, we will pay the Monthly Indemnity shown in the Policy Schedule.
- If such member is age 65 or over at the time hospital confinement commences, we will pay 50% of the Monthly Indemnity shown in the Policy Schedule during the first 3 months of such covered confinement. If such confinement continues for more than 3 months, the full Monthly Indemnity shown in the Policy Schedule will be paid during such continuous confinement beginning with the 4th month.
- If such member is an unmarried dependent child, between the ages of 1 month and 19 years, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions" set forth below. For periods of hospital confinement of less than one full month a proportionate payment will be made.

MATERNITY BENEFIT: If the Maternity Benefit is provided as specified in the Policy Schedule, or by endorsement, and by reason of pregnancy, childbirth, or miscarriage, the Covered Wife is confined to a hospital, we will pay you at the rate of the Monthly Indemnity shown in the Policy Schedule, beginning with the first day and continuing for the period of such confinement subject to the requirements that both Husband and Wife are insured under this Policy at the time hospital

confinement commences and during the entire period of pregnancy. However, coverage for the Covered Husband shall be required only at the time of conception in the event of his death or entry into the Armed Services.

NEWBORN CHILDREN: If this Policy provides coverage for unmarried dependent children between the ages of 1 month and 19 years as specified in the Policy Schedule, a child born to you and your spouse while this Policy is in force will automatically become a Covered Member at the age of 1 month. No additional premium charge will be made.

DISMEMBERMENT BENEFIT: When accidental bodily injury to a Covered Member results, within 90 days from the date of the accident causing such injury, in any of the losses specified below, we will pay you the sum set opposite the specific loss. In the event of more than one loss only one sum will be paid; the larger payment made under this provision shall be in addition to any other benefits payable under this Policy.

For injury resulting in loss of

Both hands or both feet or the sight of both eyes	\$2,000.00
One hand and one foot	\$2,000.00
One hand or one foot and sight of one eye	\$2,000.00
One hand or one foot or sight of one eye	\$1,000.00

Loss of hand or foot means severance at or above the wrist or ankle joint.

Loss of sight must be entire and irrecoverable.

SIMULTANEOUS CONFINEMENT BENEFIT: If Husband and Wife are simultaneously confined in a hospital because of injury, and while both are covered under this policy, the applicable Monthly Indemnity for hospital confinement for each will be doubled during the actual period of time that both are simultaneously confined.

REGISTERED NURSE AT HOME BENEFIT: When by reason of injury or sickness a Covered Member is continuously confined at home immediately following a period of hospital confinement of 5 consecutive days or more and for which benefits were paid under the Monthly Hospital Benefit provision, and the services of a registered nurse are employed under the direction of the attending physician and expenses for employment of such nurse are actually incurred by you, we will pay at the rate of \$400 per month for a period not to exceed the period of preceding hospital confinement and, in no event, to exceed 12 months for any one injury or sickness subject to the following limitations:

- Such nurse must be employed within 5 days following the immediately preceding period of hospital confinement.
- Such nurse shall perform not less than one full shift on any day or days such nursing care is required.
- No benefit shall be paid for nursing services rendered more than 14 months after the immediately preceding period of covered hospital confinement.

For periods of covered Registered Nurse At Home expenses of less than one full month, a proportionate payment will be made.

WAIVER OF PREMIUM PROVISION

After you have been confined in the hospital for 8 consecutive weeks while this Policy is in force and while benefits are payable under this Policy for such confinement, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment of premiums by you. After termination of such hospital confinement for which the premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy. This provision shall apply only if you (the Insured) are so confined.

DEPENDENT PERSONS; INCAPACITY AND DEPENDENCY

If a covered dependent person is incapable of self sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the policyholder for support and maintenance, and providing you furnish satisfactory proof of his incapacity to us within 60 days of our inquiry that such dependent is a disabled and dependent person, and you continue to pay the required premium we will pay the full amount of benefits listed in the Policy Schedule and the premium required will be that amount applicable for the benefit for his attained age. Such person shall continue to be eligible for as long as such incapacity continues.

TERMINATION

A covered dependent child shall cease to be covered upon his marriage, cessation of his dependency on you or on his 19th birthday, subject, however, to the Conversion Privilege and Dependent Persons; Incapacity and Dependency provisions.

CONVERSION PRIVILEGE

We will issue to any Covered Member who attains the age of 19, is married prior thereto or who ceases to be dependent on you while this Policy is in force, if he so elects by written notice to us mailed within 31 days after he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided under this Policy and at the premium rate for his attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses," will be the date such Covered Member was originally insured under this Policy. No benefits will be payable under such policy, however, for any injury or sickness for which benefits were payable under this Policy.

DEFINITIONS

"Covered Member" means you or any family member named in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children between the ages of 1 month and 19 years and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission of proper application.

"Sickness" means sickness or disease which is first manifested after the Effective Date of this Policy and while this Policy is in force.

"Injury" means accidental bodily injury sustained, directly and independently of all other causes, on or after the Effective Date of this Policy and while this Policy is in force.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is not immediately related to you.

"Nurse" means a graduate, Registered Nurse, (R.N.), who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis, and which maintains facilities for medical diagnosis and treatment of such persons by or under the supervision of a staff of physicians, and which provides 24 hour a day nursing service by and under the supervision of registered nurses; and which provides facilities for major surgery, and which is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculous sanatorium and/or hospital, or a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility owned or operated by the United States government or any of its agencies which does not require payment for its services.

"Resident Patient" means one who is confined to a Hospital and for whom a charge is made by the Hospital for each day so confined. This does not include one whose confinement is not necessary for medical treatment or who is occupying any form of rest, nursing, convalescent, rehabilitation or extended care facility.

"Continuously Confined At Home" means necessary and continuous confinement at home, under the care of a physician, which shall not be terminated by reason of necessary visits to the doctor's office or hospital and/or sitting in the sunshine upon the recommendation of your doctor.

RECURRENT CONDITIONS

After benefits have become payable under this Policy for any condition, if subsequent expenses are incurred for the same or a related condition or conditions, such expenses shall be regarded as incurred for the same injury or sickness unless separated by a continuous period of 90 days during which time the person incurring such expense has resumed full normal activities, in which case the subsequent expenses will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

EXCLUSIONS

We will not pay benefits for any loss caused by or contributed to by: (1) War or any act of war; (2) Pregnancy, except if provided under the Maternity Benefit provision; (3) Any mental disease or disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES. This Policy, together with any endorsements and papers, constitute the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES. (a) After 2 years from the Effective Date of this Policy no statements except fraudulent misstatements, made by you in the application for this Policy shall be used to void this Policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period. (b) No claim for loss incurred commencing after 2 years from the Effective Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description had existed prior to the Effective Date of this Policy.

GRACE PERIOD. A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY. If this Policy has lapsed, a subsequent acceptance of a premium by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy; provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such application unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the due date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS. Written notice of claim must be given to us within 30 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to us, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS. Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS. Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS. All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS. All benefits will be payable to you during your lifetime. Any accrued benefits unpaid at your death will be paid to your beneficiary, or in the absence of a named beneficiary, to your estate except that, at our option, we may pay any such accrued benefits, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS. At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

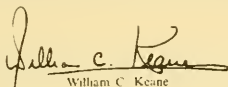
PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.


OTHER INSURANCE IN OUR COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

CLERICAL ERROR: A clerical error by us shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.

EFFECTIVE DATE: This Policy takes effect on its Effective Date and continues in force for the specified term as stated in the Policy Schedule. All periods of insurance shall begin and end at Twelve O'Clock Noon Standard Time at your residence.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our President and Secretary.


William C. Keane
Secretary


T. Robert Wilcox
President

Countersignature of licensed resident agent if required by your state.

Hospitalization
Indemnity Plan

NH 10-669 Mich.

NATIONAL HOME
LIFE ASSURANCE
COMPANY
An Old Line Legal Reserve Company
of St. Louis, Missouri
ADMINISTRATIVE OFFICES
VALLEY FORGE, PENNSYLVANIA

YOUR AGE INSURED IN THIS POLICY TERM OF THIS POLICY PREMIUM POLICY NUMBER EFFECTIVE DATE

OTHER COVERED MEMBERS

MONTHLY QUARTERLY SEMI-ANNUALLY ANNUALLY

STATE OF MICHIGAN,
DEPARTMENT OF COMMERCE,
INSURANCE BUREAU,
Lansing, Mich., March 10, 1972.

Re National Home Life Assurance Company, Accident and Health Policy Titles
NATIONAL HOME LIFE ASSURANCE Co.,
Malvern, Pa.

GENTLEMEN: In reviewing advertising, we have encountered many problems directly related to the advertising of accident and health coverage, and particularly hospital indemnity plans, which involve the use of such words as "Extra," "Cash," "Extra Cash," "Cash Income," "Income," "Investment," "Compensation," and terms of similar import. In order to eliminate misunderstandings, we have required companies to cease using such words or terms in advertising their policies in Michigan. You may be familiar with this requirement.

Under the circumstances, we believe that the titles of the policies should not include such words. If you have policies presently approved for use in Michigan, whose titles include such words, we shall permit you to exhaust your present supplies with the understanding that a change of title will in every instance be made on first reprint, or within a reasonable period of time which shall be not later than September 1, 1972.

We request that you note your records to the effect that any new form hereafter submitted, bearing an unacceptable title, will not be acted upon until the necessary correction has been made.

We shall need your acknowledgment of this letter.

Sincerely yours,

MRS. EDWINA SHEATHELM,
*Director, Policy Approval and Marketing,
Life and Health Division.*

Florida

*No pre-existing condition clause, separately reprinted***NATIONAL HOME LIFE ASSURANCE COMPANY**

An Old Line Legal Reserve Company of St. Louis, Missouri

ADMINISTRATIVE OFFICES: VALLEY Forge, PENNSYLVANIA

Extra Cash Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your," and the National Home Life Assurance Company will be referred to as "we," "our," or "us."

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided.

CONSIDERATION

This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium has been paid in advance of the Effective Date. (The postmark on the envelope containing your payment shall be considered the date of payment.)

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 15 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

**GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE
TABLE OF PREMIUM RATES**

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment, in advance or within the Grace Period, of the renewal premium at our premium rate in effect for all policies and classes of policyholders in this NH-10-699 FLA. series, in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies or such classes of policyholders in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

- If such member is under age 65 (but not an unmarried dependent child) at the time hospital confinement commences, we will pay the Monthly Indemnity shown in the Policy Schedule.
- If such member is age 65 or over at the time hospital confinement commences, we will pay 50% of the Monthly Indemnity shown in the Policy Schedule during the first 3 months of such covered confinement. If such confinement continues for more than 3 months, the full Monthly Indemnity shown in the Policy Schedule will be paid during such continuous confinement beginning with the 4th month.
- If such member is an unmarried dependent child, between the ages of 1 month and 19 years, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions" set forth below. For periods of hospital confinement of less than one full month a proportionate payment will be made.

MATERNITY BENEFIT: If the Maternity Benefit is provided as specified in the Policy Schedule, or by endorsement, and by reason of pregnancy, childbirth, or miscarriage, the Covered Wife is confined to a hospital, we will pay you at the rate of the Monthly Indemnity shown in the Policy Schedule, beginning with the first day and continuing for the period of such confinement subject to the requirements that both Husband and Wife are insured under this Policy at the time hospital confinement commences and during the entire period of pregnancy. However, coverage for the Covered Husband shall be required only at the time of conception in the event of his death or entry into the Armed Services.

NEWBORN CHILDREN: If this Policy provides coverage for unmarried dependent children between the ages of 1 month and 19 years as specified in the Policy Schedule, a child born to you and your spouse while this Policy is in force will automatically become a Covered Member at the age of 1 month. No additional premium charge will be made.

DISMEMBERMENT BENEFIT: When accidental bodily injury to a Covered Member results, within 90 days from the date of the accident causing such injury, in any of the losses specified below, we will pay you the sum set opposite the specific loss. In the event of more than one loss only one sum will be paid, the larger. Payment made under this provision shall be in addition to any other benefits payable under this Policy.

For injury resulting in loss of:

Both hands or both feet or the sight of both eyes	\$2,000.00
One hand and one foot	\$2,000.00
One hand or one foot and sight of one eye	\$2,000.00
One hand or one foot or sight of one eye	\$1,000.00

Loss of hand or foot means severance at or above the wrist or ankle joint.

Loss of sight must be entire and irrecoverable.

SIMULTANEOUS CONFINEMENT BENEFIT: If Husband and Wife are simultaneously confined in a hospital because of injury, and while both are covered under this policy, the applicable Monthly Indemnity for hospital confinement for each will be doubled during the actual period of time that both are simultaneously confined.

REGISTERED NURSE AT HOME BENEFIT: When by reason of injury or sickness a Covered Member is continuously confined at home immediately following a period of hospital confinement of 5 consecutive days or more and for which benefits were paid under the Monthly Hospital Benefit provision, and the services of a registered nurse are employed under the direction of the attending physician and expenses for employment of such nurse are actually incurred by you, we will pay at the rate of \$400 per month for a period not to exceed the period of preceding hospital confinement and, in no event, to exceed 12 months for any one injury or sickness subject to the following limitations:

- Such nurse must be employed within 5 days following the immediately preceding period of hospital confinement.
- Such nurse shall perform not less than one full shift on any day or days such nursing care is required.
- No benefit shall be paid for nursing services rendered more than 14 months after the immediately preceding period of covered hospital confinement.

For periods of covered Registered Nurse At Home expenses of less than one full month, a proportionate payment will be made.

WAIVER OF PREMIUM PROVISION

After you have been confined in the hospital for 8 consecutive weeks while this Policy is in force and while benefits are payable under this Policy for such confinement, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment of premiums by you. After termination of such hospital confinement for which the premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy. This provision shall apply only if you (the Insured) are so confined.

TERMINATION

A covered dependent child shall cease to be covered upon his marriage, cessation of his dependency on you, or on his 19th birthday. (subject, however, to the Conversion Privilege provision), except that his coverage under this Policy shall not terminate at age 19 if he is incapable of self support due to mental retardation or physical handicap and is dependent upon you for support and maintenance, providing you furnish satisfactory proof of his incapacity to us within 31 days of his 19th birthday and you continue to pay the required premium. Beginning with such child's 19th birthday the Monthly Indemnity Benefit payable for confinement will increase to the full amount listed in the Policy Schedule and the premium required will be that amount applicable to his attained age. Such child shall continue to be eligible for as long as such incapacity continues.

If we accept a premium on account of any covered dependent child which would continue coverage beyond the date of termination described above, coverage for such dependent child shall be extended for the period to which such premium applies.

CONVERSION PRIVILEGE

We will issue to any Covered Member who attains the age of 19, is married prior thereto or who ceases to be dependent on you while this Policy is in force, if he so elects by written notice to us mailed within 31 days after he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided under this Policy and at the premium rate for his attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses," will be the date such Covered Member was originally insured under this Policy. No benefits will be payable under such policy, however, for any injury or sickness for which benefits were payable under this policy.

DEFINITIONS

"Covered Member" means you or any family member named in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children between the ages of 1 month and 19 years and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission of proper application.

"Sickness" means sickness or disease which is first manifested after the Effective Date of this Policy and while this Policy is in force.

"Injury" means accidental bodily injury sustained, directly and independently of all other causes, on or after the Effective Date of this Policy and while this Policy is in force.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is not immediately related to you.

"Nurse" means a graduate, Registered Nurse (R.N.), who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis, and which maintains facilities for medical diagnosis and treatment of such persons, by or under the supervision of a staff of physicians, and which provides 24 hour a day nursing service by and under the supervision of registered nurses, and which provides facilities for major surgery, and which is not, other than incidentally, a place of rest a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculosis sanatorium and/or hospital, or a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility owned or

operated by the United States government or any of its agencies which does not require payment for its services.

"Resident Patient" means one who is confined to a Hospital and for whom a charge is made by the Hospital for each day he is confined. This does not include one whose confinement is not necessary for medical treatment or who is occupying any form of rest, nursing, convalescent, rehabilitation or extended care facility.

"Continuously Confined At Home" means necessary and continuous confinement at home, under the care of a physician, which shall not be terminated by reason of necessary visits to the doctor's office or hospital and/or sitting in the automobile upon the recommendation of your doctor.

RECURRENT CONDITION

After benefits have become payable under this Policy for any condition, if subsequent expenses are incurred for the same or a related condition or conditions, such expenses shall be regarded as incurred for the same injury or sickness unless separated by a continuous period of 90 days during which time the person incurring such expense has resumed full normal activities, in which case the subsequent expenses will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

EXCLUSIONS

We will not pay benefits for any loss caused by or contributed to by: (1) War or any act of war; (2) Pregnancy, except if provided under the Maternity Benefit provision; (3) Any mental disease or disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, together with any endorsements and papers, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred or disability commencing after 2 years from the Effective Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description had existed prior to the Effective Date of this Policy.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY: If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of a premium by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy; provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the due date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS: Written notice of claim must be given to us within 30 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to our Administrative Offices, Valley Forge, Pennsylvania, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS: Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS: Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you during your lifetime. If any benefit unpaid at your death shall be payable to your estate, or to your beneficiary who is a minor or otherwise not competent to give a valid release, we may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this promise shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS: At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.

OTHER INSURANCE IN OUR COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

CLERICAL ERROR: A clerical error by us shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our President and Secretary.

John C. Keane
Secretary

T. Robert Wilcox
T. Robert Wilcox
President

Countersignature of Licensed Resident Agent, if required by your state.

*Extra Cash
Hospitalization
Indemnity Plan*

NH 10-669 FLA.

NATIONAL HOME
LIFE ASSURANCE
COMPANY
An Old Line Legal Reserve Company
of St. Louis, Missouri
ADMINISTRATIVE OFFICES
VALLEY Forge, PENNSYLVANIA

STATE OF FLORIDA,
TREASURER'S OFFICE,
Tallahassee, Fla., July 31, 1969.

MR. WILLIAM C. KEANE,
Vice President-Secretary, National Home Life Assurance Co.,
St. Louis, Mo.

DEAR MR. KEANE: I have your letters dated June 17 and July 9, received in this office however on July 14, concerning your Gold Star policy forms.

We object to the wording in the "Consideration" clause of these policies which all appear to be similar if not identical. We do not believe we should approve a policy that is issued with the qualifications such as contained in this paragraph. If you do not wish to insure persons who use alcoholic beverages or who have been refused other insurance due to reasons of health, you may ask these questions on the application. You may attach a copy of the application to the policy when it is issued and then rescind if the applicant is not complete and accurate.

We do not believe that the pre-existing conditions which are covered in part in the "Time Limit On Certain Defenses" should be re-explained in the manner that you do in the paragraph entitled "Pre-existing Conditions". If you are not going to pay for pre-existing conditions, this policy must so state.

Your exclusion number four (4) conflicts with the second additional provision entitled "Intoxicants And Narcotics". The above applies to form NHGS-01-369 and others as applicable.

I am sorry but we cannot approve these forms and a copy of your letter of transmittal is enclosed with our stamp of disapproval.

Yours very truly,

FRANK ALEXANDER,
Deputy Insurance Commissioner,
Accident & Health Division.

NATIONAL HOME ASSURANCE COMPANY OF NEW YORK

A Legal Reserve Company of New York, New York

ADMINISTRATIVE OFFICES: VALLEY FORGE, PENNSYLVANIA

Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your," or "yours," and the National Home Assurance Company of New York will be referred to as "we," "our," or "us".

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided.

CONSIDERATION

This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium is paid within 10 days of the Effective Date, and shall continue in force until the end of the Initial Term specified in the Schedule.

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 10 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE TABLE OF PREMIUM RATES

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment, in advance or within the Grace Period, of the renewal premium at our premium rate in effect for all policies and classes of policyholders in this series, NHNY 10-669R in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies or such classes of policyholders in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

- If such member is under age 65 (but not an unmarried dependent child) at the time hospital confinement commences, we will pay the Monthly Indemnity shown in the Policy Schedule.
- If such member is age 65 or over at the time hospital confinement commences, we will pay 70% of the Monthly Indemnity shown in the Policy Schedule during the first 3 months of such covered confinement. If such confinement continues for more than 3 months, the full Monthly Indemnity shown in the Policy Schedule will be paid during such continuous confinement beginning with the 4th month.
- If such member is an unmarried dependent child, between the ages of 1 month and 19 years, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions". For periods of hospital confinement of less than one full month a proportionate payment will be made.

NEWBORN CHILDREN: If this Policy provides coverage for unmarried dependent children between the ages of 1 month and 19 years as specified in the Policy Schedule, a child born to you and your spouse while this Policy is in force will automatically become a Covered Member at the age of 1 month. No additional premium charge will be made.

PRE-EXISTING CONDITIONS: Hospital confinements commencing after the effective date of this policy shall be covered unless the illness (sickness, disease or physical condition) causing the confinement was medically advised or manifested within one year immediately prior to the effective date. Such limitation will not be invoked, however, unless the illness was a kind or of such severity that the company, in accordance with its underwriting standards applicable to the underwritten forms or to like or similar insurance, would decline such insurance or require policy modification (use of an impairment rider). See Uniform Provision entitled "Time Limit on Certain Defenses."

WAIVER OF PREMIUM PROVISION

After you have been confined in the hospital for 8 consecutive weeks while this Policy is in force and while benefits are payable under this Policy for such confinement, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment of premiums by you. After termination of such hospital confinement for which the premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy. This provision shall apply only if you (the Insured) are so confined.

TERMINATION

A covered dependent child shall cease to be covered at the end of the premium paying period following his marriage, cessation of his dependency on you, or on his 19th birthday, whichever occurs first, subject, however, to the Conversion Privilege provision.

However, coverage under this Policy shall not terminate at age 19 if he is incapable of self support due to mental retardation or physical handicap and is dependent upon you for support and maintenance, provided you furnish satisfactory proof of his incapacity to us within 31 days of his 19th birthday and you continue to pay the required dependent premium. Beginning with such child's 19th birthday, the Monthly Indemnity Benefit payable for confinements commencing thereafter will increase to the full amount listed in the Policy Schedule. Such child shall continue to be eligible for as long as such incapacity continues.

Upon the Insured Spouse ceasing to be the spouse of the Insured, because of divorce or legal separation, such person shall no longer be eligible for renewal and the coverage for such person shall terminate at the end of the then current premium paying period.

CONVERSION PRIVILEGE

We will issue to any Covered Member who attains the age of 19, is married prior thereto or who ceases to be dependent on you while this Policy is in force, if he so elects by written notice to us mailed within 31 days after the end of the premium period during which he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided to adults under age 65 under this Policy and at the premium rate for his attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses", will be the date such Covered Member was originally insured under this Policy. No benefits will be payable under such policy, however, for any injury or sickness for which benefits are payable under this Policy.

DEFINITIONS

"Covered Member" means you or any family member indicated in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children between the ages of 1 month and 19 years and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission and approval of the proper application and payment of the required additional premium (if any).

"Sickness" means sickness or disease of a Covered Member which is first manifested after the Effective Date of coverage of such member and while the coverage of this Policy is in force as to such Covered Member.

"Injury" means accidental bodily injury sustained by a Covered Member directly and independently of all other causes on or after the Effective Date of coverage of such member and while the coverage of this Policy is in force as to such Covered Member.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis, and which maintains facilities for medical diagnosis and treatment of such persons, by or under the supervision of a staff of physicians; and which provides 24 hour a day nursing service by and under the supervision of registered nurses; and which provides facilities for major surgery; and which is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculosis sanatorium and/or hospital, or a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility owned or operated by the United States government or any of its agencies which does not require payment for its services.

"Resident Patient" means one who is confined to a Hospital and is charged by the Hospital for each day so confined. This does not include one whose confinement is not necessary for medical treatment or who is occupying any form of rest, nursing, convalescent, rehabilitation or extended care facility.

RECURRENT CONDITIONS

After benefits have become payable under this Policy for any condition, if hospital confinement is required for the same or a related condition or conditions, such confinement shall be regarded as required for the same injury or sickness unless separated by a continuous period of 90 days during which time the person requiring such confinement has resumed full

EXCLUSIONS

We will not pay benefits for any loss caused by or contributed to by: (1) War or any act of war; (2) Pregnancy, miscarriage or any consequences thereof; (3) Any mental disease or disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, together with any endorsements and attached papers, if any, constitute the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred or disability commencing after 2 years from the Effective Date of a Covered Member's coverage under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of such coverage. (This provision is not to be invoked as to loss resulting from any sickness, disease or physical condition for which the Covered Member was medically advised or was manifested within one year immediately prior to the Effective Date of this insurance as to such member for which coverage would be afforded pursuant to the section captioned BENEFIT PROVISIONS.)

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY: If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of a premium by us or any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy; provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the due date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to our Administrative Offices, Valley Forge, Pennsylvania, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS: Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS: Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you during your lifetime. Any accrued benefits unpaid at your death will be paid to your beneficiary, or in the absence of a named beneficiary, to your estate, except that, at our option, we may pay any such accrued benefits, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS AND AUTOPSY: At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which, on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.

OTHER INSURANCE IN OUR COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

EFFECTIVE DATE: This Policy takes effect on its Effective Date and continues in force for the specified term as stated in the Policy Schedule. All periods of insurance shall begin and end at Twelve O'Clock Noon Standard Time at your residence.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our President and Secretary.



Alfred G. Ellis
Secretary



Arthur S. DeMoss
President

Hospitalization
Indemnity Plan

NHNY 1048 R

NATIONAL HOME
ASSURANCE COMPANY
OF NEW YORK
A Legal Reserve Company
of New York, New York
ADMINISTRATIVE OFFICES
VALLEY FORGE, PENNSYLVANIA

AMENDMENT RIDER

New Jersey

This policy is hereby amended as follows:

1. The provision of the Policy entitled "Consideration" is deleted in its entirety and the following is inserted

CONSIDERATION

This Policy is issued to you in consideration of the application and the payment of the first premium stated in the Policy Schedule. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium has been paid in advance of the Effective Date.

2. The provision of the Policy entitled "Time Limit on Certain Defenses" is deleted in its entirety and the following is inserted:

This language part 2. TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred or disability commencing after 2 years from the Effective Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of this policy.

Nothing hereby contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of this Policy, other than as above stated.

Endorsed and made a part of this Policy on the Policy Date.

NATIONAL HOME LIFE ASSURANCE COMPANY

John C. Keane
Secretary

NH NJ 3(1069)

AMENDMENT RIDER

Missouri
Covers Government Hospitals

THIS POLICY IS HEREBY AMENDED AS FOLLOWS:

The provision of this Policy entitled "Hospital" is deleted in its entirety and the following is inserted.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis; and which maintains facilities for medical diagnosis and treatment of such persons, by or under the supervision of a staff of one or more physicians; and which provides 24 hour a day nursing service by or under the supervision of registered nurses on duty or call; and which provides facilities for surgery; and which is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculosis sanatorium and/or hospital, or a nursing, convalescent rehabilitation or extended care facility. Hospital shall not mean any facility owned or operated by the United States government or any of its agencies which does not require payment for its services.

Nothing hereby contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of this Policy, other than as above stated.

Endorsed and made a part of this Policy on the Policy Date.

NATIONAL HOME LIFE ASSURANCE COMPANY

John C. Keane
Secretary

NH-MO 1(170)

Illinois

NATIONAL HOME LIFE ASSURANCE COMPANY

An Old Line Legal Reserve Company of St. Louis, Missouri

ADMINISTRATIVE OFFICE: VALLEY FORGE, PENNSYLVANIA

Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your," or "yours," and the National Home Life Assurance Company will be referred to as "we," "our," or "us."

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided.

CONSIDERATION

This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule and with the qualification that, to the best of your knowledge and belief, no Covered Member has been refused any health, hospital, or life insurance coverage due to reasons of health. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium has been paid in advance of the Effective Date. (The postmark on the envelope containing your payment shall be considered the date of payment.)

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 15 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE TABLE OF PREMIUM RATES

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment, in advance or within the Grace Period, of the renewal premium at our premium rate in effect for all policies and classes of policyholders in this series, NH-10-669 Ill. in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies or such classes of policyholders in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

PRE-EXISTING CONDITIONS

After 2 years from the date this Policy becomes effective for a Covered Member hospital confinement commencing thereafter while this Policy is in force for such Covered Member and as a result of any condition for which such Covered Member was medically treated or advised prior to the Effective Date, shall be covered hereunder. (See Uniform Provision entitled "Time Limit On Certain Defenses.")

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

- If such member is under age 65 (but not an unmarried dependent child) at the time hospital confinement commences, we will pay the Monthly Indemnity shown in the Policy Schedule.
- If such member is age 65 or over at the time hospital confinement commences, we will pay 50% of the Monthly Indemnity shown in the Policy Schedule during the first 3 months of such covered confinement. If such confinement continues for more than 3 months, the full Monthly Indemnity shown in the Policy Schedule will be paid during such continuous confinement beginning with the 4th month.
- If such member is an unmarried dependent child, between the ages of 1 month and 19 years, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions" set forth below. For periods of hospital confinement of less than one full month a proportionate payment will be made.

MATERNITY BENEFIT: If the Maternity Benefit is provided as specified in the Policy Schedule, or by endorsement and by reason of pregnancy, childbirth, or miscarriage, the Covered Wife is confined to a hospital, we will pay you at the rate of the Monthly Indemnity shown in the Policy Schedule, beginning with the first day and continuing for the period of such confinement subject to the requirements that both Husband and Wife are insured under this Policy at the time hospital

confinement commences and during the entire period of pregnancy. However, coverage for the Covered Husband shall be required only at the time of conception in the event of his death or entry into the Armed Services.

NEWBORN CHILDREN: If this Policy provides coverage for unmarried dependent children between the ages of 1 month and 19 years as specified in the Policy Schedule, a child born to you and your spouse while this Policy is in force will automatically become a Covered Member at the age of 1 month. No additional premium charge will be made.

DISMEMBERMENT BENEFIT: When accidental bodily injury to a Covered Member results, within 90 days from the date of the accident causing such injury, in any of the losses specified below, we will pay you the sum set opposite the specific loss. In the event of more than one loss only one sum will be paid, the larger. Payment made under this provision shall be in addition to any other benefits payable under this Policy.

For injury resulting in loss of

Both hands or both feet or the sight of both eyes	\$2,000.00
One hand and one foot	\$2,000.00
One hand or one foot and sight of one eye	\$2,000.00
One hand or one foot or sight of one eye	\$1,000.00

Loss of hand or foot means severance at or above the wrist or ankle joint.

Loss of sight must be entire and irrecoverable.

SIMULTANEOUS CONFINEMENT BENEFIT: If Husband and Wife are simultaneously confined in a hospital because of injury, and while both are covered under the policy, the applicable Monthly Indemnity for hospital confinement for each will be doubled during the actual period of time that both are simultaneously confined.

REGISTERED NURSE AT HOME BENEFIT: When by reason of injury or sickness a Covered Member is continuously confined at home immediately following a period of hospital confinement of 5 consecutive days or more and for which benefits were paid under the Monthly Hospital Benefit provision, and the services of a registered nurse are employed under the direction of the attending physician and expenses for employment of such nurse are actually incurred by you, we will pay at the rate of \$400 per month for a period not to exceed the period of preceding hospital confinement and, in no event, to exceed 12 months for any one injury or sickness subject to the following limitations:

- Such nurse must be employed within 5 days following the immediately preceding period of hospital confinement.
- Such nurse shall perform not less than one full shift on any day or days such nursing care is required.
- No benefit shall be paid for nursing services rendered more than 14 months after the immediately preceding period of covered hospital confinement.

For periods of covered Registered Nurse At Home expenses of less than one full month, a proportionate payment will be made.

WAIVER OF PREMIUM PROVISION

After you have been confined in the hospital for 8 consecutive weeks while this Policy is in force and while benefits are payable under this Policy for such confinement, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment of premiums by you. After termination of such hospital confinement for which the premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy. This provision shall apply only if you (the insured) are so confined.

DEPENDENT PERSONS; INCAPACITY AND DEPENDENCY

If a covered dependent person is incapable of self sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the policyholder for support and maintenance, and providing you furnish satisfactory proof of his incapacity to us within 60 days of our inquiry that such dependent is a disabled and dependent person and you continue to pay the required premium we will pay the full amount of benefits listed in the Policy Schedule and the premium required will be that amount applicable for the benefit for his attained age. Such person shall continue to be eligible for as long as such incapacity continues.

TERMINATION

A covered dependent child shall cease to be covered upon his marriage, cessation of his dependency on you or on his 19th birthday, subject, however, to the Conversion Privilege and Dependent Persons, Incapacity and Dependency provisions.

CONVERSION PRIVILEGE

We will issue to any Covered Member who attains the age of 19, is married prior thereto or who ceases to be dependent on you while this Policy is in force, if he so elects by written notice to us mailed within 31 days after he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided under this Policy and at the premium rate for his attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses," will be the date such Covered Member was originally insured under this Policy. No benefits will be payable under such policy, however, for any injury or sickness for which benefits were payable under this Policy.

DEFINITIONS

"Covered Member" means you or any family member named in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children between the ages of 1 month and 19 years and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission of proper application.

"Sickness" means sickness or disease which is first manifested after the Effective Date of this Policy and while this Policy is in force.

"Injury" means accidental bodily injury sustained, directly and independently of all other causes, on or after the Effective Date of this Policy and while this Policy is in force.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is not immediately related to you.

"Nurse" means a graduate, Registered Nurse, (R.N.), who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis, and which maintains facilities for medical diagnosis and treatment of such persons by or under the supervision of a staff of physicians, and which provides 24 hour a day nursing service by and under the supervision of registered nurses, and which provides facilities for major surgery, and which is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculosis sanatorium and/or hospital, or a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility owned or operated by the United States government or any of its agencies which does not require payment for its services.

"Resident Patient" means one who is confined to a Hospital and for whom a charge is made by the Hospital for each day so confined. This does not include one whose confinement is not necessary for medical treatment or who is occupying any form of rest, nursing, convalescent, rehabilitation or extended care facility.

"Continuously Confined At Home" means necessary and continuous confinement at home, under the care of a physician, which shall not be terminated by reason of necessary visits to the doctor's office or hospital and/or sitting in the sunshine upon the recommendation of your doctor.

RECURRENT CONDITIONS

After benefits have become payable under this Policy for any condition, if subsequent expenses are incurred for the same or a related condition or conditions, such expenses shall be regarded as incurred for the same injury or sickness unless separated by a continuous period of 90 days during which time the person incurring such expense has resumed full normal activities, in which case the subsequent expenses will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

EXCLUSIONS

We will not pay benefits for any loss caused by or contributed to by (1) War or any act or war, (2) Pregnancy, except if provided under the Maternity Benefit provision, (3) Any mental disease or disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, together with any endorsements and papers, constitute the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: (a) After 2 years from the Effective Date of this Policy no statements except fraudulent misstatements, made by you in the application for this Policy shall be used to void this Policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period. (b) No claim for loss incurred commencing after 2 years from the Effective Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description had existed prior to the Effective Date of this Policy.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY: If this Policy has lapsed, a subsequent acceptance of a premium by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy, provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us, or, lacking such approval, upon the 45th day following the date of such application unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the due date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to us, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS: Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS: Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you during your lifetime. Any accrued benefits unpaid at your death will be paid to your beneficiary, or in the absence of a named beneficiary, to your estate that, at our option, we may pay any such accrued benefits, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS: At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

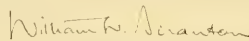
PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.

OTHER INSURANCE IN OUR COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

CLERICAL ERROR: A clerical error by us shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our Chairman of the Board and Secretary.


William C. Keane
Secretary


William W. Scranton
Chairman of the Board

Countersignature of licensed resident agent if required by your state.

Hospitalization
Indemnity Plan

NH-10-600 11L

NATIONAL HOME
LIFE ASSURANCE
COMPANY
An Old Line Local Reserve Company
of St. Louis, Missouri
ADMINISTRATIVE OFFICE
VALLEY FORGE, PENNSYLVANIA

California *children covered from*
moment of birth
either prior - children
covered from
after
birth

NATIONAL HOME LIFE ASSURANCE COMPANY

An Old Line Legal Reserve Company of St. Louis, Missouri

ADMINISTRATIVE OFFICES VALLEY FORGE, PENNSYLVANIA

Extra Cash Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your," or "yours," and National Home Life Assurance Company will be referred to as "we," "our," or "us."

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided. We will not pay benefits for confinement in any facility contracted for or operated by the United States Government for the treatment of members or ex-members of the Armed Forces.

CONSIDERATION

This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule. It shall take effect on the Effective Date specified in the Policy Schedule.

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 15 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE TABLE OF PREMIUM RATES

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment in advance or within the Grace Period, of the renewal premium at our premium rate in effect for all policies in this series, NH 10-669 Cal. R., in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

PRE-EXISTING CONDITIONS

Injuries sustained or sickness first manifested before the Effective Date of this Policy will be covered for loss incurred after this Policy has been in force for two years. Other injuries or sickness will be covered as of the Effective Date.

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

If such member is an unmarried dependent child, under 19 years of age, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions". For periods of hospital confinement of less than one full month a proportionate payment will be made.

MATERNITY BENEFIT: If the Maternity Benefit is provided as specified in the Policy Schedule, or by endorsement, and by reason of pregnancy, childbirth or miscarriage, the Covered Wife is confined to a hospital, we will pay you at the rate of the Monthly Indemnity shown in the Policy Schedule for the period of such confinement subject to the requirement that the Wife is insured under this Policy at the time hospital confinement commences and during the entire period of pregnancy.

NEWBORN CHILDREN: If the Policy Schedule specifies coverage for unmarried dependent children under 19 years of age, a child born to you and your spouse while the Policy is in force will automatically become a Covered Member. No additional premium charge will be made.

DISMEMBERMENT BENEFIT: When accidental bodily injury to a Covered Member results, within 90 days from the date of the accident causing such injury, in any of the losses specified below, we will pay you the sum set opposite the specific loss. In the event of more than one loss only one sum will be paid, the larger. Payment made under this provision shall be in addition to any other benefits payable under this Policy.

For injury resulting in loss of:

Both hands or both feet or the sight of both eyes	\$2,000.00
One hand and one foot	\$2,000.00
One hand or one foot and sight of one eye	\$2,000.00
One hand or one foot or sight of one eye	\$1,000.00

Loss of hand or foot means severance at or above the wrist or ankle joint.

Loss of sight must be entire and irrecoverable.

SIMULTANEOUS CONFINEMENT BENEFIT: If husband and wife are simultaneously confined in a hospital because of injury, and while both are covered under this Policy, the applicable Monthly Indemnity for hospital confinement for each will be doubled during the actual period of time that both are simultaneously confined.

REGISTERED NURSE AT HOME BENEFIT: When by reason of injury or sickness a Covered Member is continuously confined at home immediately following a period of hospital confinement of 5 consecutive days or more and for which benefits were paid under the Monthly Hospital Benefit provision, and the services of a registered nurse are employed under the direction of the attending physician and expenses for employment of such nurse are actually incurred by you, we will pay at the rate of \$400 per month for a period not to exceed 12 months for any one injury or sickness subject to the following limitations:

- a) Such nurse must be employed within 5 days following the immediately preceding period of hospital confinement.
- b) Such nurse shall perform not less than one full 8-hour shift on any day or days such nursing care is required.
- c) No benefit shall be paid for nursing services rendered more than 14 months after the immediately preceding period of covered hospital confinement.

For periods of covered Registered Nurse At Home expenses of less than one full month, a proportionate payment will be made.

WAIVER OF PREMIUM PROVISIONS

After you or your spouse has been confined in a hospital for 8 consecutive weeks following the Elimination Period, if any, and while this Policy is in force, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment by you. After termination of such hospital confinement for which premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy.

TERMINATION

A covered dependent child shall cease to be covered upon the earlier to occur of the premium due date coinciding with or next following his marriage, his nineteenth birthday, or his ceasing to be living in your household except while attending college; (subject, however, to the Conversion Privilege provision), except that his coverage under this Policy shall not terminate at age 19 if he is incapable of self support due to mental retardation or physical handicap and is chiefly dependent upon you for support and maintenance, providing you furnish satisfactory proof of his incapacity to us within 31 days of his 19th birthday and you continue to pay the required premium. Beginning with such child's 19th birthday the premium required will be that amount applicable to his attained age. Such child shall continue to be eligible for as long as such incapacity continues. If we accept a premium on account of any covered dependent child which would continue coverage beyond the date of termination described above, coverage for such dependent child shall be extended for the period to which such premium applies. If a covered dependent child is hospitalized within 90 days of termination, by reason of injury or sickness originating while the policy is in force, benefits under this Policy for such dependent child shall be extended for the period to which confinement continues. Wherever used in this paragraph, "19th birthday" shall mean the premium due date coinciding with or next following the 19th birthday of a covered dependent child.

CONVERSION PRIVILEGE

We will issue to any Covered Member who ceases to be covered upon the earlier to occur of the premium due date coinciding with or next following his marriage, his nineteenth birthday, or his ceasing to be living in your household except while attending college while this Policy is in force, if he so elects in written notice to us mailed within 31 days after he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided under this Policy and at the premium rate for his attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses" will be the date such Covered Member was originally insured under this Policy. No benefits will be payable under such policy, however, for any injury or sickness for which benefits were payable under this Policy.

DEFINITIONS

"Covered Member" means you or any family member named in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children under 19 years of age and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission of proper application.

"Sickness" means sickness or disease which is first manifested after the Effective Date of this Policy and while this Policy is in force.

"Injury" means accidental bodily injury sustained on or after the Effective Date of this Policy and while this Policy is in force.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is neither your spouse nor immediately related to you.

"Nurse" means a graduate, Registered Nurse, (R.N.), who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis, and which maintains facilities for medical diagnosis and treatment of such persons by or under the supervision of a staff of one or more physicians; and which provides 24 hour a day nursing service by and under the supervision of registered nurses; and which provides facilities for surgery, and which is not other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility contracted for or operated by the United States Government for the treatment of members or ex-members of the Armed Forces.

"Resident Patient" means one who is confined to a hospital. This does not include one whose confinement is not necessary for medical treatment or who is using the institution primarily as a form of rest, nursing, convalescent, rehabilitation or extended care facility.

"Continuously Confined At Home" means necessary and continuous confinement at home, under the care of a physician, which shall not be terminated by reason of necessary visits to the doctor's office or hospital and/or sitting in the sunshine upon the recommendation of your doctor.

RECURRENT CONDITIONS

After benefits have become payable under this Policy for any condition, if subsequent hospital or home confinement is incurred for the same or related condition or conditions, such confinement shall be regarded as incurred for the same injury or sickness unless separated by a continuous period of 90 days during which time the person incurring such confinement has resumed full normal activities in which case the subsequent confinement will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

EXCLUSIONS

We will not pay benefit for any loss caused by: (1) War or any act of war, (2) Pregnancy, except if provided under the Maternity Benefit provision; (3) Any mental disease or functional nervous disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, together with any endorsements and attached papers, if any, constitute the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred after 2 years from the Effective Date of this Policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description had existed prior to the Effective Date of this Policy.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY: If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of a premium by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy, provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the due date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to our Administrative Offices: Valley Forge, Pennsylvania, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS: Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS: Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you during your lifetime. Any accrued benefits unpaid at your death will be paid to your beneficiary, or in the absence of a named beneficiary, to your estate except that, at our option, we may pay any such accrued benefits, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS: At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

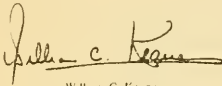
UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.

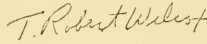
OTHER INSURANCE IN OUR COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

CLERICAL ERROR: A clerical error by us shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our President and Secretary.



William C. Keane
Secretary



T. Robert Wilcox
President

Countersignature of licensed resident agent if required by your state

Extra Cash
Hospitalization
Indemnity Plan

NH 10-669 Cal R

NATIONAL HOME
LIFE ASSURANCE
COMPANY
An Old Line Legal Reserve Company
of St. Louis, Missouri
ADMINISTRATIVE OFFICES
VALLEY FORGE, PENNSYLVANIA

POLICY CONTRACT				
YOU (INSURED)	PERIOD OF INSURANCE	PREMIUM	POLICY NUMBER	EFFECTIVE DATE
JOHN DOE	ONE MONTH	\$1.00	X000000	11/16/71
MARY DOE	\$400 MONTHLY INDEMNITY PAYMENT BEGINS ON THE 4TH DAY OF HOSPITALIZATION FOR SICKNESS			
ALL DEPENDENT CHILDREN UNDER 19 AS PROVIDED IN THE POLICY CONTRACT	DEPENDENT CHILDREN ARE INCLUDED MATERNITY BENEFITS ARE INCLUDED			
	\$X.XX	\$XX.XX	\$XX.XX	\$XX.XX

New York

Up to Jan. 1, 1972

NATIONAL HOME ASSURANCE COMPANY OF NEW YORK

An Old Line Legal Reserve Company of New York, New York

ADMINISTRATIVE OFFICES, VALLEY Forge, PENNSYLVANIA

Hospitalization Indemnity Plan

In this Policy, the Insured will be referred to as "you," "your," or "yours," and the National Home Assurance Company of New York will be referred to as "we," "our," or "us".

We will pay benefits to you for loss incurred hereunder resulting from injury or sickness, to the extent herein limited and provided.

CONSIDERATION

- This Policy is issued to you in consideration of the payment of the first premium stated in the Policy Schedule. It shall take effect on the Effective Date specified in the Policy Schedule, provided the first premium is paid within 10 days of the Effective Date, and shall continue in force until the end of the Initial Term specified in the Schedule.

RIGHT TO EXAMINE POLICY

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within 10 days from the date you receive it, to us or to any of our authorized agents. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid on it will be refunded to you.

GUARANTEED RENEWABLE FOR YOUR LIFETIME SUBJECT TO OUR RIGHT TO CHANGE TABLE OF PREMIUM RATES

We guarantee to renew this Policy as long as you live, subject to its terms and conditions, and to the timely payment, in advance or within the Grace Period, of the renewal premium at our premium rate in effect for all policies and classes of policyholders in this series, NHNY 10-669 in the state, territory or country in which you reside at the time of such renewal, and we agree that no adjustment in premium rate shall be made on this Policy unless such adjustment is made on all such policies or such classes of policyholders in the state, territory or country in which you reside at the time of such adjustment. Any such adjustment will be based on the ages and sex of the Covered Members on the Effective Date of this Policy.

BENEFIT PROVISIONS

MONTHLY HOSPITAL BENEFIT: When injury or sickness necessitates hospital confinement of a Covered Member as a Resident Patient at the direction and under the care of a physician, commencing while this Policy is in force for such Covered Member, we will pay for the period of such confinement, beginning with the first day of any such continuous confinement as a result of injury and beginning with the day of such continuous confinement as shown in the Policy Schedule as a result of sickness, an amount per month equal to the Monthly Indemnity shown in the Policy Schedule, subject to the following:

- If such member is under age 65 (but not an unmarried dependent child) at the time hospital confinement commences, we will pay the Monthly Indemnity shown in the Policy Schedule.
- If such member is age 65 or over at the time hospital confinement commences, we will pay 70% of the Monthly Indemnity shown in the Policy Schedule during the first 3 months of such covered confinement. If such confinement continues for more than 3 months, the full Monthly Indemnity shown in the Policy Schedule will be paid during such continuous confinement beginning with the 4th month.
- If such member is an unmarried dependent child, between the ages of 1 month and 19 years, we will pay 60% of the Monthly Indemnity shown in the Policy Schedule for the covered period of confinement.

These benefits are subject to the provision entitled "Recurrent Conditions" set forth below. For periods of hospital confinement of less than one full month a proportionate payment will be made.

NEWBORN CHILDREN: If this Policy provides coverage for unmarried dependent children between the ages of 1 month and 19 years as specified in the Policy Schedule, a child born to you and your spouse while this Policy is in force will automatically become a Covered Member at the age of 1 month. No additional premium charge will be made.

- ✓ **PRE-EXISTING CONDITIONS:** Hospital confinements commencing after the effective date of this policy shall be covered unless the illness (sickness, disease or physical condition) causing the confinement was medically advised or manifested within two years immediately prior to the effective date. Such limitation will not be invoked, however, unless the illness was a kind of or of such severity that the company, in accordance with its underwriting standards applicable to the underwritten forms or to like or similar insurance, would decline such insurance or require policy modification (use of an impairment rider). See Uniform Provision entitled "Time Limit on Certain Defenses."

WAIVER OF PREMIUM PROVISION

After you have been confined in the hospital for 8 consecutive weeks while this Policy is in force and while benefits are payable under this Policy for such confinement, we will waive all premiums which become due on this Policy during the further period of such confinement and this Policy will remain in full force during the period for which premiums are waived, subject to all its conditions, except as to payment of premiums by you. After termination of such hospital confinement for which the premiums are waived, this Policy shall continue in force until the next premium due date at which time you shall have the right to resume payment of premiums as provided in this Policy. This provision shall apply only if you (the Insured) are so confined.

TERMINATION

A covered dependent child shall cease to be covered at the end of the premium paying period following his marriage, cessation of his dependency on you, or on his 19th birthday, whichever occurs first, subject, however, to the Conversion Privilege provision.

However, coverage under this Policy shall not terminate at age 19 if he is incapable of self support due to mental retardation or physical handicap and is dependent upon you for support and maintenance, provided you furnish satisfactory proof of his incapacity to us within 31 days of his 19th birthday and you continue to pay the required dependent premium. Beginning with such child's 19th birthday, the Monthly Indemnity Benefit payable for confinements commencing thereafter will increase to the full amount listed in the Policy Schedule. Such child shall continue to be eligible for as long as such incapacity continues.

Upon your insured spouse ceasing to be your spouse, because of divorce, legal separation or marriage annulment, such person shall no longer be eligible for renewal under this policy and the coverage for such person shall terminate at the end of the then current premium paying period. Such person shall have the right of conversion as stated in the Conversion Privilege provision. In the event of your death while this policy is in force, if your spouse is included as a Covered Member, then such spouse shall become the principal Insured.

CONVERSION PRIVILEGE

We will issue to any Covered Member who attains the age of 19; who is married prior to age 19; who ceases to be dependent on you; who is divorced or separated from you; whose marriage has been annulled; and while this policy is in force, if he so elects by written notice to us mailed within 31 days after the end of the premium period during which he has ceased to be eligible as a Covered Member under this Policy, an individual policy providing the benefits then being issued by us which are most nearly similar to but not greater than those provided to adults under age 65 under this policy and at the premium rate for such person's attained age upon conversion. No evidence of insurability will be required for such policy, and the Effective Date, for the purpose of interpreting the provision entitled "Time Limit on Certain Defenses", will be the date such Covered Member was originally insured under this Policy. No benefits will be payable under such policy, however, for any injury or sickness for which benefits are payable under this Policy.

DEFINITIONS

"Covered Member" means you or any family member indicated in the Policy Schedule or in a subsequent amendment thereto; provided, however, that only you, your spouse, and unmarried dependent children between the ages of 1 month and 19 years and any other adults dependent on you are eligible to be Covered Members. Covered Members may either be included at the time of original issue or may be added at a later time while this Policy is in force upon submission and approval of the proper application and payment of the required additional premium (if any).

"Sickness" means sickness or disease of a Covered Member which is first manifested after the Effective Date of coverage of such member and while the coverage of this Policy is in force as to such Covered Member.

"Injury" means accidental bodily injury sustained by a Covered Member directly and independently of all other causes on or after the Effective Date of coverage of such member and while the coverage of this Policy is in force as to such Covered Member.

"Physician" means a duly licensed physician or duly licensed practitioner who is practicing within the scope of his license and who is not immediately related to you.

"Hospital" means an institution whose principal purpose is providing medical care and treatment for injured and sick persons on a resident patient basis; and which maintains facilities for medical diagnosis and treatment of such persons, by or under the supervision of a staff of physicians; and which provides 24 hour a day nursing service by and under the supervision of registered nurses; and which provides facilities for major surgery; and which is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a mental institution, a tuberculosis sanatorium and/or hospital, or a nursing, convalescent, rehabilitation or extended care facility. Hospital shall not mean any facility owned or operated by the United States government or any of its agencies which does not require payment for its services.

"Resident Patient" means one who is confined to a Hospital and is charged by the Hospital for each day so confined. This does not include one whose confinement is not necessary for medical treatment or who is occupying any form of rest, nursing, convalescent, rehabilitation or extended care facility.

RECURRENT CONDITIONS

After benefits have become payable under this Policy for any condition, if hospital confinement is required for the same or a related condition or conditions, such confinement shall be regarded as required for the same injury or sickness unless separated by a continuous period of 90 days during which time the person requiring such confinement has resumed full normal activities, in which case the subsequent confinement will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

normal activities, in which case the subsequent confinement will be considered to result from a new injury or sickness, subject to the limitations and conditions of this Policy.

EXCLUSIONS

We will not pay benefits for any loss caused by or contributed to by: (1) War or any act of war; (2) Pregnancy, miscarriage or any consequences thereof; (3) Any mental disease or disorder.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, together with any endorsements and attached papers, if any, constitute the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred or disability commencing after 2 years from the Effective Date of a Covered Member's coverage under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of such coverage. (This provision is not to be invoked as to loss resulting from any sickness, disease or physical condition for which the Covered Member was medically advised or was manifested within two years immediately prior to the Effective Date of this insurance as to such member for which coverage would be afforded pursuant to the section captioned BENEFIT PROVISIONS.)

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force.

REINSTATEMENT OF POLICY: If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of a premium by us or any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy; provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval. This reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than 10 days after such date. In all other respects you and we shall have the same rights as each had under this Policy immediately before the date of the defaulted premium, subject to any restrictions which are attached in connection with the reinstatement.

NOTICE OF CLAIMS: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this Policy or as soon thereafter as is reasonably possible. Notice given by you or on your behalf to our Administrative Offices, Valley Forge, Pennsylvania, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS: Upon receipt of a notice of claim we will furnish you such forms as are usually furnished by us for filing proofs of loss. If we do not furnish such forms within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, character and extent of loss.

PROOF OF LOSS: Written proof of loss must be furnished to us or to any of our authorized agents in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Your failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible for you to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you during your lifetime. Any accrued benefits unpaid at your death will be paid to your beneficiary, or in the absence of a named beneficiary, to your estate, except that, at our option, we may pay any such accrued benefits, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of yours who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

PHYSICAL EXAMINATIONS AND AUTOPSY: At our own expense we shall have the right and opportunity to examine any Covered Member when and as often as we may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy or after the expiration of 3 years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES: Any provision of this Policy, which, on its Effective Date, is in conflict with the statutes of the state in which you and other Covered Members reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

MISSTATEMENT OF AGE: If the age of any Covered Member has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

PREMIUM PAYMENT: Each renewal premium is due at the expiration of the premium period for which the preceding premium was paid. Premiums are payable to us or to our duly authorized representative. The payment of any premium shall not continue this Policy in force beyond the next premium due date, except as otherwise provided herein.

OTHER INSURANCE IN OUR COMPANY: Insurance effective at any one time for a Covered Member under a like Policy or Policies in this Company is limited to the one such Policy elected by such Covered Member, his beneficiary, or his estate, as the case may be. We will return all premiums paid for all other such Policies.

EFFECTIVE DATE: This Policy takes effect on its Effective Date and continues in force for the specified term as stated in the Policy Schedule. All periods of insurance shall begin and end at Twelve O'Clock Noon Standard Time at your residence.

IN WITNESS WHEREOF, we have caused this Policy to be signed by our President and Secretary.

Alfred G. Gillis

Arthur S. DeMoss
President

Hospitalization
Indemnity Plan

NHNY 10-685

**NATIONAL HOME
ASSURANCE COMPANY
OF NEW YORK**
An Old Line Legal Reserve Company
of New York, New York

ADMINISTRATIVE OFFICES
VALLEY Forge, PENNSYLVANIA

YOUNG, B. 1962

NOTES ON CONTRIBUTORS

INR 44-7524	FIRST PREMIUM	POLICY NUMBER	EFFECTIVE DATE

[illegible]

1000

1998

100

100

100

10

24

CONCLUSIONS AND FUTURE RESEARCH

Page 10 of 10

CONCLUSIONS

1990年1月1日

100

100

100

100

100

OTHER COVERED MEMBERS

14

Notes

五、

115

3 Months 6 Months

[Advertisement from the Baltimore Sunday Sun, Jan. 9, 1972]

For first month's protection, mail Enrollment Form with 25 cents before midnight, Tuesday, Feb. 1, 1972, to get up to \$600 a month tax free cash when you go to the hospital to help pay for the things your other insurance doesn't cover.

Cash to help pay for the "deductibles" and "extras."

Cash to help make up for lost paychecks.

Cash to help pay for a housekeeper or practical nurse.

Cash to help keep the kids in school.

Cash so Mom won't have to look for a job.

Cash so you won't have to borrow.

CONTENTS

	Page
Why we charge only 25 cents for your first month-----	2
How this policy never runs out-----	3
Cash benefits for parent, child, nurse at home, etc-----	4
Table of exclusions-----	4
Table of rates (from ages 16 to 65)-----	5
How these low rates are possible-----	5
Enrollment form-----	6

COLLECT AT THE RATE OF \$600 A MONTH TAX-FREE CASH WHEN YOU'RE IN THE HOSPITAL

We have a great family insurance policy for you. It pays at the rate of up to \$600 a month for adults (\$360 a month for covered children) for as long as they stay in the hospital. If husband and wife are hospitalized for injury at the same time, it pays \$2,400 a month!

After you've reached age 65, you're paid half-benefits, but only for your first three months in the hospital. From then on, you collect *full benefits* for as long as you stay. If you've already reached age 65, please write for special information.

Your first month's premium—just 25 cents. To attract as many new policyholders as possible, we charge only 25 cents for the first month.

But be warned. The odds are heavily against your needing hospital care during your first month. But there's a fifty-fifty chance that *someone* in your family will go to the hospital this year. If it happens to you, you'll find our benefits a godsend.

Tax-free cash paid directly to you. The money is tax-free, which makes \$600 worth from \$711 up to \$816 in monthly income, even more if you're in a high tax bracket. And it is paid directly to you—not to any doctor or hospital. If you have bills to pay, you decide who gets paid first. If you're free and clear, you can put the money in the bank.

Regular hospitalization insurance isn't enough. Do you have group insurance where you work? A Blue Cross Hospitalization Plan? A Blue Shield Medical Plan? Major Medical? Or are you on Medicare? You'll find, if you get to the hospital, that most policies like these don't pay all of your bills.

Take Medicare. Today there is a \$68 Hospital deductible and a \$50 Medical deductible. Then there is 80-20 co-insurance on the medical portion (they pay 80% of the bill and you pay 20%). Finally, there are maximum allowances for each type of medical service. If a doctor charges more than the allowance—as many do—you have to pay the difference.

So if you run up a \$1,000 medical-hospital bill, you'll probably have to pay some \$200 yourself. Quite possibly more.

This national home policy never runs out. Most people don't discover the limitations of their insurance until they go to the hospital. Then it's too late.

For example, do you know that most group policies have a dollar limit on what they pay? That many run out in six months? Do you realize, in other words, that a long illness might put your family on welfare?

Our policy never runs out. If you have to spend the rest of your life in the hospital, we pay you for the rest of your life. At full benefits. If a husband and wife are hospitalized for injury at the same time, we pay double benefits—up to \$2,400 a month—and we pay it for life, if necessary.

The National Home policy has very few *ifs*, and *or buts*. You can understand it in just a few minutes. The tables on the next two pages explain exactly what you get, what you don't get, and what you pay.

Get started for a quarter. Most important, though, is that it cost only 25¢ to cover you and your entire family for the first month. That gives you plenty of time to study our policy and see how it fills the gaps in the insurance you already have.

If you like your policy, you can renew it for as little as \$3.45 a month. Or return it in 15 days and get your money back.

If you keep the policy and anything happens to you during that first month, you're covered. At the rate of \$600 a month.

HERE'S WHAT WE PAY (OVER AND ABOVE MEDICARE AND ALL OTHER INSURANCE)

When you're under 65. \$600 a month cash when you go to the hospital, starting the sixth day with illness and the 1st day with injury. Payments continue as long as you are hospitalized—for life if necessary. Or,

\$2,400 a month cash from the very first day both husband and wife are hospitalized for injury. Payments continue as long as both are hospitalized—for life if necessary. Plus—

\$360 a month cash when a covered child (18 and under) goes to the hospital, starting the sixth day for illness and the 1st day for injury. Payments continue as long as the child is in hospital.

\$400 a month cash for registered nurse at home ordered by doctor within 5 days of a covered hospital stay of 5 days or more. Limit: 12 months or length of hospital stay, whichever is less.

Up to \$2,000 cash for complete accidental loss of limbs or eyesight.

We also pay all your premiums after you, the policyholder, have been confined by a covered hospitalization for 8 weeks in a row. We pay the premiums for your entire family plus your monthly benefits until you leave the hospital. We pay them for life if necessary.

After you reach age 65. \$300 a month cash when you go to the hospital, starting the sixth day with illness and the 1st day with injury. Payments continue for three months, then become. . . .

\$600 a month cash for as long as you're hospitalized—for life if need be. Or,

\$1,200 a month cash from the 1st day both husband and wife are hospitalized for injury. Payments continue for three months, then become. . . .

\$2,400 a month cash for as long as both are hospitalized—for life if necessary. Plus—

Benefits for Dependent Child, Registered Nurse at Home, Accidental Dismemberment and Waiver of Premium are the same as when you're under 65.

Here's what we don't pay. This policy does not cover confinements in Government hospitals or hospitalizations due to:

1. War or Act of War.
2. Mental disorder or acts committed while intoxicated or under the influence of narcotics.

3. Pregnancy. Note: *If you add Maternity Benefits and Coverage for Children, we cover all such confinements from 1st day for childbirth, miscarriage, etc.*

4. Preexisting conditions which manifested themselves before start of policy. Note: *Even these conditions are covered after policy is in force for 2 continuous years.*

HERE'S WHAT YOU PAY

(Note: These rates will not go up as you get older. They will not go up if you make frequent claims or large claims. Nor can the company cancel your policy for these or any other reasons. Only a statewide adjustment (up or down) of all policies like yours can ever change your rate. And no one can cancel this policy but you.)

Age at enrollment:	Monthly premium per adult ¹
Under 45 (minimum age, 16) -----	\$3. 45
45 to 49 -----	4. 00
50 to 54 -----	4. 40
55 to 64 -----	5. 10

¹ All Premiums lower if paid in advance quarterly, semi-annually or annually.

USE THIS COUPON IF YOU ARE 65 OR OVER

Send No Money—Just Mail This Coupon To:

National Home, Valley Forge, Pa. 19481

Please send me complete information on your special health plan for folks 65 or over. I understand there is no obligation, no cost, and no salesmen or agent will call.

Print

Name -----

Address -----

City ----- State ----- Zip -----

Age ----- Date of Birth -----

Add \$1.80* per month to cover all unmarried children under 19. Dependent Child Coverage ends at Age 19 or marriage, subject to Conversion Privilege in the policy. Newborn and adopted children are covered automatically at 1 month at no extra charge, if you have selected Dependent Child Coverage.

Add \$1.35* per month to above for Maternity Benefits payable from 1st day of confinement.

No catch to our low rates. When you see premiums this low, you'd suspect that the policy is full of clauses that make pay outs few and far between. This is not the case.

Look high and low through the provisions set forth in this ad. Let your lawyer or insurance agent help. You'll find no unusual exclusions.

Indeed, we feel that this plan's payout provisions are among the most liberal available. For example:

- We pay benefits on Workmen's Compensation cases. Many policies don't.
- We pay benefits for life if necessary. Many policies have a 1-year or 2-year limit.
- We pay benefits for a registered nurse at home after hospitalization. Most policies don't.
- We continue your insurance regardless of age. Some policies cancel you after a certain age.
- We excuse you from paying premiums when you are hospitalized longer than 8 weeks in a row. Most policies don't.

How then are these low rates possible?

You are looking at the answer. We sell insurance by mail. And administer it by mail. And have cut the cost of contacting you down to postage stamp size.

We have sold over two million low-cost policies this way, and today mail out an average of \$1-million in benefit checks each and every month.

Your neighborhood letter carrier makes it possible. He delivers more insurance for your money. And you don't even pay him a commission.

SIGN UP HERE FOR \$600 TAX-FREE CASH WHEN YOU GO TO THE HOSPITAL

No Age Limit—No Salesmen Will Call—To Cover Your Entire Family for 1st Month, Mail Completed Form with 25 cents

OFFICIAL ENROLLMENT FORM

Official Enrollment Form for the Hospitalization Indemnity Plan, National Home Life Assurance Company, an Old Line Legal Reserve Company of St. Louis, Missouri, Administrative Office: Valley Forge, Pennsylvania

Name -----

Address -----

City ----- State ----- Zip -----

Date of Birth ----- Age ----- Sex Male ☐ Female ☐

Occupation -----

List all dependents to be covered under this Plan: (Do Not include name that appears above. Use separate sheet if necessary.)

Name (please print)	Relation- ship	Sex	Date of birth			Age
			Month	Day	Year	
1.						
2.						
3.						
4.						
5.						

☐ Check here if you want Coverage for Your Children.

☐ Check here if you want Coverage for Your Children and Maternity Benefits.

I hereby enroll in National Home's Hospital Plan and am enclosing the first month's premium to cover myself and all others listed above. I understand that hospital confinements due to pre-existing conditions will not be covered unless commencing after two years of continuous coverage from the Effective Date of Policy, but that I will be covered for other conditions immediately upon issue of the Policy, subject to the policy provisions dealing with commencement of coverage.

Signature X _____ Date _____

Mail this enrollment form before midnight Feb. 1, 1972.

National Home Life Assurance Company, a division of National Liberty Corporation, Adm. Offices: Valley Forge, Pennsylvania 19481. Est. 1920—Over 50 Years of Reliable Service.

Advertising Supplement to

The Washington Post

THIS ENROLLMENT PERIOD ENDS SOON!
 YOU MUST REPLY BEFORE MIDNIGHT,
 SATURDAY, JUNE 12, 1971

NO HEALTH QUESTIONS
 TO ANSWER DURING THIS
 ENROLLMENT PERIOD!!!

Extra Cash

for people of all ages

UP TO \$100.00-A-WEEK

when you go to the hospital!

At last, here is a plan that actually pays you: • EXTRA CASH up to \$25,000 • EXTRA CASH in the hospital up to 250 weeks • EXTRA CASH paid directly to you • EXTRA CASH to help cover *uncovered* medical expenses • EXTRA CASH in addition to Blue Cross, Medicare, or any other insurance!

NOW—and only until the date shown above—You can have CASH protection regardless of your age or the size of your family.

And, you get the first month's protection for only \$1.

SEE INSIDE FOR EXTRA CASH BENEFITS



You get up to \$100.00 a week Tax-Free

For a hospital stay lasting up to 250 weeks

WORDS OF PRAISE FROM SATISFIED POLICYOWNERS

Thank you for check for settlement. It is a pleasure to know you have this protection these days.

Charles E. Crow
West Lafayette, Indiana



Excellent service—money paid in excess of hospital expense and fed the family.

J. F. Smith
Titusville, Florida

Very well pleased with the service—glad I took advantage of your offer.

Mr. S.A. Taylor
Cinnaminson, New Jersey



I am very pleased with your service on my claim. Certainly had no idea I would be making one so soon after taking out policy . . . It will be a big help and I'm glad to have it.

Mrs. A.W. Martin
Walpole, New Hampshire



I am very pleased with your handling of my claim. When purchasing this insurance there was no indication we would need it so soon. Your advertising was very honest. Thank you.

Catherine J. Overby
Weaverville, North Carolina

Now . . . you and your family can join this Extra Cash Hospital Income Plan with ■ no red tape ■ no age limit ■ without having to see a salesman

You know, of course, that the tremendous jump in hospital costs has forced millions who already have hospital insurance to dig into savings or go into debt. Even with Medicare they risk using up their savings or, worse yet, turning to family and friends for help. In fact, very few people have enough savings, hospital insurance or income to cover the TOTAL cost of being sick or injured.

How long could you stay in the hospital without worrying about the pile-up of daily expenses? Who will pay for costly X-rays, doctor bills, drugs and medicines? And how about the at home expenses — rent, food, telephone and others that just go on and on? With expenses like these, could you avoid having your savings wiped out and your family life upset?

Wouldn't it be comforting to know these problems could be eased by your Extra Cash Hospital Income Plan — the Plan that gives you up to \$100.00 a week — IN CASH — tax-free from your first day in the hospital for accident and after the third day for sicknesses for up to 250 full weeks.

Extra Cash Up To \$25,000.00

You can be secure, knowing that when you have to go to the hospital, you will receive:

- Up to \$100.00-a-week tax-free when you go to the hospital
- Up to \$100.00-a-week to a maximum of \$25,000 for any hospital stay lasting 250 weeks!
- Up to \$100.00-a-week sent directly to you—not doctor or hospital
- Up to \$100.00-a-week in addition to hospitalization, Workmen's Compensation, Medicare, or any other insurance!

Now have peace of mind

Everything costs more these days. Hospital costs alone have **TRIPLED** in just a few short years . . . and they're expected to **DOUBLE** soon. Even though most Americans have some hospital insurance, most find that the benefits simply *don't cover ALL* the bills that keep mounting up when sickness or accident strikes. Union Fidelity has created this low-cost Extra Cash Hospital Income Plan to help cover your **UNCOVERED** expenses while hospitalized . . . to put **EXTRA CASH** in your hand for bills from the doctor, the surgeon, the nurse, the druggist or anyone else who provides service and treatment you need and want.



EXTRA CASH GIVES PEACE

This Offer Expires Soon.

\$1 Protects Your Entire Family for the First Month.

To encourage you to see how valuable this Plan is, we are making this unusual offer with a *Money-Back Guarantee*. Just fill in the Enrollment Form on the back page of this booklet and mail it with only \$1 before midnight of the expiration date. A *full month's protection* will go into effect on the very day we issue your policy (generally the same day we receive your Enrollment Form).

When you receive your policy, take your time to examine it carefully. It's written to be easy to understand. There is **NO FINE PRINT**. *Show it to any trusted advisor—your doctor, your lawyer, your clergyman. In fact, show it to your own insurance man . . . even though he probably works for another insurance company!* If he is a personal friend, he wants what is best for you. So you can believe him when he tells you there is no better value available anywhere.

Even then, if you're not completely satisfied, return the policy within 30 days and your money will be cheerfully refunded with *no questions asked*. However, if you decide to continue this worthwhile protection, you may do so at these low rates:

POLICY FORM 440
UNION FIDELITY MONTHLY RENEWAL RATES

Age at Enrollment	Monthly Premium Per Person
0-18	only \$1.60
19-39	only \$2.85
40-54	only \$3.60
55-64	only \$4.35
65-74	only \$5.10
75 and over	only \$6.80

NOTE: The regular Monthly Premium shown here (for your age at time of enrollment) will never increase because you pass from one age bracket to the next. It won't even change because of frequent claims or the amount of money you collect. It can change only if there is a general rate adjustment affecting all policies of this type in your state.



**AND REMEMBER —
FIRST MONTH'S PROTECTION,
EVEN FOR THE ENTIRE
FAMILY, IS ONLY \$1!**

OF MIND AND SECURITY

BENEFITS FOR ILLNESS AFTER 3RD DAY REDUCES COST DRASTICALLY!

How can we offer so much protection for so little? By having policy benefits for sickness start immediately after your 3rd day in the hospital, we can avoid the small one, two or three day claims which run up our operating costs. And the savings are passed on to *you*! Remember, too, benefits are payable from the very *first* day for accident. In either case, benefits continue while you are in the hospital for AS LONG AS 250 WEEKS — up to \$25,000.00!

THESE ARE THE ONLY EXCLUSIONS!

The new Union Fidelity Extra Cash Hospital Income Plan covers you from your first day in the hospital for any accident, and after your third day in the hospital for all sicknesses which begin after the effective date of your policy except, of course, hospitalization caused by mental disorders; act of war; pregnancy, childbirth, and miscarriage; or care provided in a Federal government hospital. Of course, you are not covered for pre-existing conditions, but even these conditions will be covered for hospital confinements beginning after the policy has been in force for only 2 continuous years.

THE NATIONALLY RESPECTED COMPANY BEHIND YOUR POLICY

As important as the cash income itself, the low cost and ease of enrollment is this *one vital fact*: Your policy is backed by the resources, integrity, and national reputation of Union Fidelity Life Insurance Company of Philadelphia, an old line legal reserve company licensed in 49 states, Washington, D.C., Puerto Rico and Canada.

FOR ONLY \$1 YOU CAN HAVE PEACE OF MIND

Join Now. You *must* mail the Enrollment Form **BEFORE** the Midnight deadline. We will issue your Extra Cash Hospital Income Plan and *put it in force* the very same day we accept your Form.

Why not take a moment right now to fill in your Enrollment Form and mail it with only \$1, the cost for your first month's coverage.

NO RISK MONEY-BACK GUARANTEE

Because we're so confident this Extra Cash Hospital Income Plan that **PAYS CASH directly to you** is the best low-cost protection now available, we make our famous Money-Back Guarantee. When you get your policy look it over. You *must* be 100% satisfied that your Plan is exactly what we promise and exactly what *you* want. If you're not, send the policy back to us within 30 days and we will **REFUND YOUR MONEY IN FULL . . . AT ONCE**. But meanwhile, if you decide to keep this policy, you will be protected.

Mail your Enrollment Form and \$1 in the postage-paid envelope **TODAY**.

JOIN NOW!

You must reply **BEFORE** the date shown on the Enrollment Form. If your Form is mailed later, we will not issue your policy. You would have to wait until the next enrollment period. Time is precious! Get your Enrollment Form and \$1 in the mail . . . **TODAY!**

Even If You Are Over 65

This Extra Cash Hospital Income Plan Pays You Cash in Addition to Medicare and Other Insurance!

This Plan is an absolute must, now that YOUR share of hospital costs has increased under Medicare!

Even though Medicare will pay most of your hospital expenses, it just can't cover everything. Your Extra Cash Hospital Income Plan helps solve this problem by paying **\$100.00 a week, in cash, directly to you**, for as long as 250 weeks . . . and gives you the privilege of spending this money any way you want to. With your total benefit amounting to as much as \$25,000.00 you may never have to worry about turning to your children or charity. You'll keep your financial independence and enjoy the *peace of mind* that this Plan's **EXTRA CASH** will give you.

ABSOLUTELY NO LIMIT ON AGE

This Plan welcomes you no matter what your age is — and *without any red tape!* Even if you're over 75 you're still eligible . . . provided, of course, that you fill in and mail the Enrollment Form during this enrollment period.

Here are 17 important

**That tell you how Union Fidelity's \$100.00
gives you the protection you**

1. How much will this Plan pay me when I go to the hospital?
You will receive up to \$100.00 per week.
2. When will my Extra Cash benefits start?
Benefits start from the day you enter the hospital for accident and after your third day in the hospital as a result of sickness.
3. Will I be paid if I am in the hospital for less than a full week?
Of course you will! You will receive cash at the rate of \$14.28 per day from the first day for accident and after the third day for sickness.
4. When does this Plan become effective?
Your protection will begin on the very day we issue your policy (generally the same day we receive your Enrollment Form).
5. How long will I continue to receive my Extra Cash?
For as long as you're in the hospital for any covered sickness or accident, for up to 250 weeks — as much as \$25,000.00.
6. Is there any red tape to join?
No. We only ask you to complete and mail your Enrollment Form before the deadline date shown.
No salesman will call.
7. Suppose I collect Extra Cash benefits for a certain sickness or accident. What happens if I go back to the hospital for the same condition — am I out of luck?
Get ready for a welcome surprise. You collect *more* cash! You go back to collecting up to \$100.00 a week until you've been hospitalized for a total of 250 weeks and have collected \$25,000.00. Then, if the same condition puts you back in the hospital after you have resumed your normal activities for six months, you become eligible to receive up to \$100.00 a week again, for up to 250 additional weeks. Any new condition will be covered immediately, of course.
8. How may I use these benefit payments?
You may use them any way you wish — for hospital and doctor bills, rent, food, household expenses or anything else. You alone decide how to use the money.
9. Why do I need your Extra Cash Plan in addition to my other insurance?
Chances are your present hospital insurance won't cover all your hospital and medical expenses. Even if it did, you will still need extra cash to help cover all your household expenses.
10. May I join if I am over 65?
Yes. You are welcome to join no matter what your age is. This Plan has no age limit.

Questions and Answers

**a-Week Extra Cash Hospital Income Plan
need—at amazingly low cost!**

11. Can you drop me or raise my rate because of health reasons?

No. We will never cancel or refuse to renew your policy because of your health or the number of times you collect benefits. Also, we guarantee that we will never adjust your rate unless we take the same action with regard to all policies of this type in your state.

12. What is not covered by this policy?

The only conditions not covered are hospitalization caused by mental disorders; act of war; pregnancy, childbirth and miscarriage; or care provided in a Federal government hospital. You are not covered for pre-existing conditions, but even these conditions will be covered for hospital confinements beginning after the policy has been in force for only 2 continuous years.

13. Can other members of my family take advantage of this special offer?

Yes. Just add their names to the Enrollment Form when you fill it in.

14. Why is this offer good for a limited time only?

Because by enrolling a large number of people at the same time our underwriting, processing and policy issue costs

can be kept at a minimum. These savings, of course, are passed on to you.

15. What other advantages are there of joining this Plan now?

By joining now you do not need to complete a regular application—just the brief form on the reverse side of this page. Also, during this enrollment period, there are no other qualifications—no “waivers” or restrictive endorsements can be put on your policy.

16. How does the Money-Back Guarantee work?

Examine your policy carefully in the privacy of your home. If for any reason you are not completely satisfied, return it within 30 days and we will promptly refund your money. Meanwhile, if you decide to keep this policy, you will be protected while making your decision.

17. How do I join?

Fill in the brief Enrollment Form (be sure to sign your name) and mail it with just \$1.00 for the first month's protection in the postage-free envelope provided. No stamp is needed.

**\$1 ENROLLMENT FORM ON BACK PAGE MUST BE
MAILED BY MIDNIGHT OF DATE SHOWN ON FORM ►
• NO SALESMAN WILL CALL •**

\$1⁰⁰ no risk enrollment offer

Money-Back Guarantee

You can enroll in this Plan without risk or obligation. When you receive your policy, take your time to examine it carefully. Show it to any trusted advisor — your doctor, lawyer, clergyman, EVEN TO YOUR OWN INSURANCE MAN. He will assure you that there is no better value available anywhere. Even then, if you're not completely satisfied, return the policy within 30 days and your money will be cheerfully and promptly refunded, with no questions asked. Mail NOW — Enrollment Period ends Midnight of Deadline Date on Enrollment Form below. We will not accept any applications mailed after the expiration date. **FILL OUT THE APPLICATION FORM BELOW AND RETURN IT WITH ONE DOLLAR IN THE POSTAGE-PAID ENVELOPE PROVIDED.**



NO SALESMAN WILL CALL

UNION FIDELITY
LIFE INSURANCE COMPANY
Union Fidelity Building, Philadelphia, Pa. 19102

*Union Fidelity is
Licensed by the States of
Maryland, Virginia,
Pennsylvania, Delaware
and the
District of Columbia.*

This Enrollment Period Expires Midnight, Saturday, June 12, 1971

Do not delay. Fill out and mail Enrollment Form today with only \$1
(regardless of the number of people to be protected)
Use the handy envelope inside this booklet—no stamp is needed

440

OFFICIAL ENROLLMENT FORM No. 01-7699-161-04

NAME (Please Print) ^{MR.} ^{MRS.} ^{MISS} _____
(Ladies, if Married, Use Your First Name) First Middle Initial Last
ADDRESS _____

CITY _____ Street or R.D. No. _____ STATE _____ ZIP _____

DATE OF BIRTH _____ Month _____ Day _____ Year _____ AGE _____ SEX Male ☐ Female ☐

I also apply for coverage for the members of my family listed below: (DO NOT repeat name that appears above)

NAME (Please Print)	RELATIONSHIP	SEX	DATE OF BIRTH			AGE
			MONTH	DAY	YEAR	
1. _____						
2. _____						
3. _____						
4. _____						
5. _____						

1. Do you carry other insurance in this company? (If "yes", please list policy no's)
YES ☐ NO ☐

2. Have you ever been hospitalized in the past 3 years? If yes, explain

Health Question is Waived
During This Enrollment Period

I have enclosed my first monthly premium of \$1.00 and hereby apply to Union Fidelity Life Insurance Company, Philadelphia, Pennsylvania 19102. I understand the policy is not in force until actually issued.

If for any reason I am not completely satisfied with the new protection I may return my Policy for cancellation within thirty (30) days and my payment will be promptly refunded.

SIGNATURE: X _____ DATE: _____
APP 400 (REV) Sign—Do not print 04

Advertising Supplement to
The News
 Saturday, April 1, 1972

**"I urge you to send 25¢
now to protect your family
 with this \$600 a month
 extra cash plan"**

Art Linkletter

For first month's protection, mail Enrollment Form with 25¢
 before midnight, Tuesday, April 11, 1972, to get up to



\$600 A MONTH TAX FREE CASH

when you go to the hospital

■ **UNDER 65?** Pays you cash at the rate of
 \$600.00 a month for each hospital stay
 given for life, if necessary.

■ **65 OR OVER?** Pays \$300.00 a month cash
 for the first 3 months when you are 65 or
 over and \$600.00 a month thereafter.

■ **COVERAGE FOR ACCIDENTS** begins
 the first day in the hospital; for sickness,
 the sixth day.

■ **HAVE CHILDREN?** Pays \$300.00 a month
 cash if a covered child is hospitalized
 for injury or illness. And the benefits
 continue for as long as necessary.

■ **PAYS ALL CASH** direct to you—pays in
 addition to any other companies' coverage.

Dear Friend:

You know me. I wouldn't recommend anything I didn't honestly believe in. And I think National Home's plan, paying up to \$600 a month, is just about the best additional financial protection you can give your family -- especially in these days of rising medical costs.

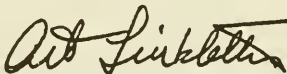
That's why I'm happy to give this plan my wholehearted endorsement.

I've looked over the policy very carefully. I've even made a point of getting to know some of the folks at National Home. And you won't find more decent, friendly people. I've seen the way they handle claims, too -- quickly and generously. Believe me, when you need them, they'll be there to help you.

That's why I cannot imagine anybody passing up the chance to enroll in this health plan -- especially when the first month's protection costs only 25c.

We all know what a terrible thing it is to be hospitalized. But what a relief it is to know there's tax-free cash coming in when you need it most! Take my advice. Send the enrollment form on the back page now -- before you forget.

Sincerely,



Art Linkletter



You collect up to \$600 extra cash...

--that's \$20.00 a day--when you require hospital care... for each accident starting the first day in the hospital; and for each illness, starting the sixth day, continuing for life, if necessary.

once you have reached age 65, in addition to Medicare benefits for the first 3 months of hospitalization. Coverage for accidents begins the very first day in the hospital; sickness coverage begins the sixth day. After 3 months, if you are still in the hospital, you then receive...

thereafter--even for life, if necessary. This money is paid directly to you in addition to Medicare or any other coverage you may already have.

when your child goes to the hospital for any accident or illness, when you have Coverage for Children--no matter how long the confinement may be. Coverage for accidents begins the very first day in the hospital; sickness coverage begins the sixth day.

for maternity benefits when Coverage for Children and Maternity Benefits have been added to the basic plan.

for a registered nurse at home if your doctor has you hire one within five days following a covered hospital confinement of five days or more for as long as you were hospitalized--up to one year.

for complete accidental loss of limbs or eyesight. If you suffer complete loss of a hand or foot or the sight of an eye within 90 days of the accident, you collect \$1,000--and \$2,000 for the loss of two limbs or the sight of both eyes.

\$1,200 a month for you--and \$1,200 a month for your spouse... when an accident hospitalizes covered husband and wife at the same time. Yes, you collect \$2,400 A MONTH in all (when under 65) while both are in the hospital--even for life.

that come due for you while you are confined to the hospital and for all covered members of your family should you--the policyowner--be hospitalized for eight consecutive weeks or more. We pay all your premiums while you are confined, in addition to your regular benefits--and you don't have to pay us back.

No age limit • No salesman or agent will call

OVER 30 million people will be admitted to a hospital this year! It could be you --or some beloved member of your family--tomorrow... next week... next month. Sad to say, very few families have anywhere near enough coverage to meet today's soaring hospital costs. These costs have more than doubled in just a few short years.

Stop for a moment. Think how much a long stay in the hospital will cost you or a loved one. How would you ever pay for costly, but necessary, X-rays, doctor bills, drugs and medicines? This plan from National Home gives you extra cash to use as you see fit for your day-to-day expenses.

Now you can have \$600.00 cash coming in every month--beginning the very first day you enter the hospital due to an accident, and the sixth day for confinements due to sickness.

The cash is paid directly to you in addition to whatever you may receive from your insurance with any other companies. Use the money as you see fit -- for hospital or doctors' bills. To help replace savings or cover household expenses.

How much does \$600.00 a month protection cost you? Only 25¢ covers you and your

entire family for the first month. After that you may continue at our regular low rates.

if you up to \$150.00 a month cash if any unmarried dependent child is hospitalized.

When you choose Coverage for Children, this National Home plan pays you at the rate of \$360.00 a month cash when one of your children is hospitalized. Pays for as long as necessary! Children are covered for accidents from the first day and for sickness from the sixth day. Dependent children's coverage ends at age 19 or upon marriage, subject to the Conversion Privilege provision in your policy.

We guarantee never to cancel your protection no matter how many claims you have . . . or how old you become . . . or for any reason whatsoever.



We guarantee never to raise your low rates because of how old you become . . . or how many claims you have . . . but only if there is a general rate adjustment on all policies of this class in your entire state.

Pays you up to \$600.00 a month for Maternity Benefits!

If both husband and wife are insured for the entire period of pregnancy (and have added Coverage for Children and Maternity Benefits), you get tax-free cash to use any way you want. Yes, if a pregnancy, childbirth or even miscarriage puts you in the hospital for one day, five days, ten days—as long as necessary—you get cash benefits for every day of your confinement.

Pays you up to \$400.00 a month cash for a Registered Nurse at Home.

How comforting it is to know that—after your stay in the hospital, if you've been there five days or more for which you received benefits—you can return home to recuperate and yet not be a burden to your loved ones. If your doctor has you employ a full-time registered nurse within 5 days after you come home, we'll pay you benefits up to \$400.00 a month while you are continuously confined at home. And your benefits continue for the same number of covered days

that you were in the hospital—even up to 12 full months.

Double Cash Accident Benefit.

When you and your insured spouse are hospitalized at the same time for an accidental injury, this National Home plan pays each of you DOUBLE CASH. Up to \$1,200.00 a month apiece. That's \$2,400.00 in cash payments every month (when under age 65) starting the day you enter the hospital for as long as you both remain there.

Pays you up to \$2,000.00 cash for these accidental losses . . .

If loss occurs within 90 days of the accident, you collect \$1,000.00 for the complete loss of a hand or a foot or the sight of an eye—and \$2,000.00 for loss of two limbs or the sight of both eyes.

Waiver of premium benefit.

After you, the policyowner, have been confined for 8 continuous weeks or more, your premiums that come due are taken care of by National Home. And your protection continues just the same as if you were paying the premiums yourself.

These are the only exclusions!

Your National Home policy covers every kind of sickness or accident except conditions caused by: war, or any act of war; any mental disease or disorder; the use of intoxicants and narcotics; pregnancy, except as provided under the Maternity Benefit provision; and pre-existing conditions which manifested themselves before start of policy (and even these conditions are covered after policy is in force for 2 continuous years). You will be covered for care in any hospital, except a U.S. Government hospital, mental institution, TB sanitarium, or a nursing or convalescent facility.

Nationally known and respected.

This is the kind of outstanding protection you may have seen in *Reader's Digest*, *Better Homes & Gardens*, *TV Guide* and other leading publications. National Home is an old line legal reserve Company licensed in 46 states and is currently helping thousands of policyowners throughout the country with their hospital and medical expenses. National Home Life Assurance Company holds the highest policyholder rating avail-

—THE BOARD OF DIRECTORS INCLUDES:—



Frank Carlson,
U.S. Senator
(1950-1960).



W. Marvin Watson,
U.S. Postmaster Gen.
(1966-1969).



Robert E. Slater,
President,
John Hancock
Mutual Life Insur.
Co. (1966-1969).



Emerson Foote,
Director,
Am. Cancer Society.

25¢ covers you the first month. Then continue your protection at monthly rates as low as \$3.45.

able from both *Best's* and *Dunne's*, the two leading rating authorities in the insurance industry. These ratings attest to the Company's ability to meet its obligations to its policyholders.

Fast, Reliable Claim Service

"We were most happy with the prompt way that you sent us the claim forms when requested. Your check for the week my husband was in the hospital was received within ten days. Thank you so much—it really helped in a time of need."

MRS. ROBERT H. ROBINSON, Miami, Fla.

"I took out the policy and had only paid two monthly premiums when I was unexpectedly put in the hospital. Was there 11 days and the National Home Life Assurance Company paid exactly what they had said they would. How happy we were we had taken the policy out."

DEWEY M. FAIROR, Upper Sandusky, Ohio

Why you must act before the date shown on your Enrollment Form — just a few days from today.

Why do we give you so little time to enroll in this plan? Because this is a *limited* enrollment offer, we can open the enrollment only during a limited time period—with a *firm* deadline date for *everyone*. To provide you with this broad coverage at these rates, we must receive your Enrollment Form during the same period as all the others.

Here are your low rates.

The following chart shows how little it costs after the first month, to cover yourself, your spouse or any adult dependent. Naturally, at these low rates, we can issue you only one policy of this type. Each adult, 16 or over, pays the rate shown for his or her age.

Age at Enrollment	Monthly Premium per Adult
16-44	only \$3.45
45-49	only \$4.00
50-54	only \$4.40
55-64	only \$5.10

Only \$1.80 more per month covers all your unmarried dependent children ... from the age of 1 month through 18 years. If you have selected dependent children coverage, newborn children are covered *automatically* at the age of one month—at no additional cost! And then, if you wish, just add \$1.35 monthly to that, and you're covered for Maternity Benefits, too!

NOTE: The regular monthly premium shown (for age at time of enrollment) will not automatically increase as you pass from one age bracket to the next. Once you have enrolled in this National Home plan, your rate can never be changed because of how much or how often you collect from us—or because of advanced age — but only if there is a general rate adjustment, on all policies of this class in your entire state.

Act now—"later" may be too late! Send just 25¢ for first month's coverage. **TIME IS PRECIOUS!** Act quickly. (No salesman will call.) Get your Enrollment Form into the mail today—because once you suffer an accident or sickness, it's **TOO LATE** to buy protection at any cost. That's why we urge you to act today—*before* the unexpected happens.



65 OR OVER?

Write for complete information on our health plan for folks 65 or over. Just print your name and address on the coupon on the back page of this booklet; then cut it out and mail it in the postpaid reply envelope. We will promptly send you full details.

MONEY-BACK GUARANTEE

We will send your National Home policy by mail. Examine it carefully. If you decide that you don't want to continue as a member of this plan, return the policy within 15 days of the date you receive it, and we will promptly refund your money.

J. Robert Welles

PRESIDENT
National Home Life Assurance Company

This special enrollment period ends midnight, Tuesday, Apr. 11, 1972

25¢ enrolls you in a health plan that pays you up to \$600 a month tax-free cash

NO AGE LIMIT • NO SALESMAN WILL CALL



See Art Linkletter's Message Inside

OFFICIAL ENROLLMENT FORM

Official Enrollment Form for the Hospitalization Indemnity Plan
NATIONAL HOME LIFE ASSURANCE COMPANY

An Old Line Legal Reserve Company of St. Louis, Missouri
ADMINISTRATIVE OFFICE: VALLEY FORGE, PENNSYLVANIA

(Please Print)

3-2468-8-05

MR. _____
MRS. _____
MISS _____
Name First Middle Initial Last

Address _____
Street or R.O. # _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex Male ☐ Female ☐
Month Day Year

Occupation _____

List all dependents to be covered under this Plan: (DO NOT include name that appears above. Use separate sheet if necessary.)

NAME (Please Print)	RELATIONSHIP	SEX	DATE OF BIRTH			AGE
			MONTH	DAY	YEAR	
1						
2						
3						
4						
5						

☐ Check here if you want Coverage for Your Children.

☐ Check here if you want Coverage for Your Children and Maternity Benefits.

I hereby enroll in National Home's Hospital Plan and am enclosing the first month's premium to cover myself and all others listed above. I understand that hospital confinements due to pre-existing conditions will not be covered unless commencing after two years of continuous coverage from the Effective Date of Policy, but that I will be covered for other conditions immediately upon issue of the Policy, subject to the policy provisions dealing with commencement of coverage.

Signature X _____ Date _____

NHA-1GR Md.

NH-10 669 MD, EP 5 (600)

LICENSED BY THE STATE OF MARYLAND

HOW TO GET YOUR POLICY

1. Complete this brief Enrollment Form.
2. Cut out along dotted line.
3. Enclose Form with 25¢ in reply envelope inside and mail to NATIONAL HOME, Valley Forge, Pa. 19481



**NATIONAL HOME
HEALTH
PLAN.**

National Home Life Assurance Company

a subsidiary of National Liberty Corporation

Adm. Offices: Valley Forge, Pennsylvania

This policy is underwritten by National Home Life Assurance Company, an old line legal reserve company of St. Louis, Missouri. National Home is licensed by your state and carries full legal reserves for the protection of all policyowners.

Established 1900—Over 80 Years of Reliable Service

3-2468-8-05

USE THIS COUPON IF YOU ARE 65 OR OVER.

Please send me complete information on your special health plan for folks 65 or over. I understand there is no obligation . . . no cost . . . and no salesman or agent will call.

NAME (Please Print) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AGE _____ DATE OF BIRTH _____

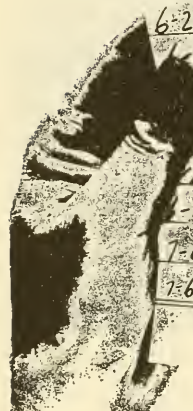
© Copyright 1971, National Liberty Corporation

USE REPLY ENVELOPE INSIDE

MAIL THIS ENROLLMENT FORM BEFORE MIDNIGHT, APR. 11, 1972

40 + 1/100

If you had an accident today, could you pay this hospital bill?



6-21-71	AMBULANCE	100	00
6-21-71	ROOM and BOARD / 6 Days @ \$40. ⁰⁰	640	00
6-22-71	LABORATORY EXAMINATIONS	50	00
6-23-71	X-RAY EXAMINATIONS	85	00
6-23-71	DRUGS and DRESSINGS	27	95
6-24-71	ANAESTHESIA SERVICE	90	00
6-25-71	OPERATING ROOM <input checked="" type="checkbox"/> DELIVERY ROOM <input type="checkbox"/>	100	00
6-27-71	PHYSICAL THERAPY	142	00
7-6-71	TELEPHONE SERVICE	16	40
7-6-71	SUNDRIES	6	00
TOTAL CHARGES 6-21-71 to 7-6-71		1257	35

Now — just 25¢ for the first month covers you and your entire family in this plan that pays **\$1,000.00** -a-month tax-free cash when you are hospitalized — no matter how long — even if you are covered by other health plans.

HURRY! 25¢ LIMITED ENROLLMENT PERIOD MUST END MIDNIGHT, DECEMBER 14, 1971.

Pays you up to \$1,000.00-a-month tax-free cash—even for life—

when you are hospitalized by an accident.
Pays in addition to any other coverage you may have.

25¢
covers you and your
entire family for
the first month

- NO SALESMAN WILL CALL
- NO MEDICAL EXAMINATION
- NO AGE LIMIT

YES, now the Accident Division of National Home Life Insurance Company will pay you *all* of this tax-free cash whenever you or someone in your family is hospitalized because of an accident...

You receive cash benefits at the rate of \$1,000.00 a month whenever you or your covered wife are hospitalized—even for life, if necessary!

You receive cash benefits at the rate of \$700.00 a month, when you are 65 or over, for the first three months you are hospitalized and \$1,000.00 a month thereafter while you remain hospitalized!

You receive cash benefits at the rate of \$500.00 a month whenever a covered child is hospitalized—for as long as necessary!

You receive cash benefits at the rate of \$3,000.00 a month if you and your covered wife (both under age 65) are hospitalized at the same time—even for life, if necessary.

PLUS up to \$5,000.00 at the rate of \$500.00 a month when your doctor has you employ a full-time registered nurse to care for you at home when you leave the hospital! And coverage continues for as long as you were continued—up to 12 full months.

PLUS up to \$2,000.00 for complete accidental loss of limbs or eyesight!

And if you act now, and mail your Enrollment Form before the deadline date...

Only 25¢ covers your family for the first month.

That's right, only 25¢ provides you and your entire family with your first full month's coverage. Then you may continue at regular National Home rates amounting to just pennies a day.

In return, all cash benefits are paid *direct* to you (not to the hospital or doctor, unless you wish). These cash benefits begin the *very first day* of hospitalization and continue for as long as you are in the hospital, even for life, if necessary.

And these cash benefits are paid *in addition* to whatever other insurance you may have...even Medicare, if you are 65 or over. Spend this *tax-free cash* any way you see fit...you don't have to account for this money to anyone.

- PAYS YOU \$1,000.00 A MONTH FOR ALL COVERED ACCIDENTS... ANYWHERE... ANYTIME... 24 HOURS A DAY... 7 DAYS A WEEK!
- PAYS YOU \$700.00 A MONTH, WHEN YOU ARE 65 OR OVER, FOR FIRST 3 MONTHS AND \$1,000.00 A MONTH THEREAFTER WHILE YOU REMAIN HOSPITALIZED.
- PAYS YOU \$500.00 A MONTH WHEN A COVERED CHILD IS HOSPITALIZED... PAYS ALL CASH DIRECT TO YOU (NOT TO THE DOCTOR OR HOSPITAL).

GUARANTEED RENEWABLE FOR LIFE.

National Home guarantees never to cancel your protection no matter how old you become or how many claims you have. Only you can cancel. Also, your rates can never be changed unless there is a general rate adjustment on all policies of this type in your entire state.



Why you and your family need this National Home protection.

What if you or someone in your family were struck "out of the blue" by an accident, and, through no fault of your own, were hospitalized, not just for a few days, but for weeks or months or even years?

Where in the world would you get the money to pay for all the expenses that pile up? Hospital room charges... X-rays... laboratory tests... operating room or intensive care charges... blood and drugs... surgeons' fees and the care of specialists... anesthesia... and a dozen and one other costs.

Even if you have some other hospital insurance, would it cover all your bills? Right now, the average cost for a hospital stay in Dallas is \$81.15... in Kansas City, \$70.86... in New York, \$86.92... in Los Angeles, \$101.73. And the U.S. Social Security Administration expects hospital charges will go up 70% more in the next five years!

And where would you get the money to pay all the day-in, day-out bills that go on piling up at home? The rent or mortgage payments... food for the family... electricity, gas, and telephone... car payments or other installment debts. Other hospital insurance, major medical insurance, even Medicare won't pay a penny of these bills.

You need additional cash protection! And this National Home policy (NH15-1169) will help to relieve you of worry about the terrible financial threat that arises when an accident puts you or a covered family member in the hospital.

Even if you are 65 or over, you enjoy cash protection.

Yes, this National Home plan pays you no matter how old you are. When you are 65 or over, you collect benefits at the rate of \$700.00 a month for the first three months you are hospitalized and \$1,000.00 a month thereafter while you remain hospitalized... *all in addition* to your Medicare benefits!

Waiver-of-premium benefit.

Here is another valuable benefit of this National Home plan. Should you—the policyholder—be hospitalized for 8 consecutive weeks or more, National Home will PAY ALL PREMIUMS that come due for you and all covered members of your family while you are confined to the hospital beyond the initial 8-week period. And your protection continues just the same as if you were paying the premiums yourself. This Waiver-of-Premium benefit continues for as long as you are hospitalized—even for life, if necessary.

Your cash protection is 'Guaranteed Renewable for Life.

As long as you pay your premiums, your National Home protection can never be cancelled for any reason whatsoever... no matter how many claims you have or how old you become or for any other reason. You are protected in full because your policy contains a *Guaranteed-Renewable-for-Life* clause. Only you can cancel your protection, if you wish.

These are the only exclusions.

You are covered for every kind of accident... *everywhere* in the world... 24 hours *every day*. The only exclusions are hernia; injuries caused by act of war; participation in any speed contest or professional athletics; or any intentionally self-inflicted injury while sane or insane. You are covered in any hospital except, of course, a U.S. Government hospital or a nursing or convalescent facility.

As a matter of fact, even if you are totally blind or deaf, or you are an epileptic or diabetic, you can be eligible for 50% of all this plan's regular benefits.

Commended in the Congressional Record

"For providing service beyond the expected," the National Liberty Corporation group of companies has been commended in the Congressional Record of the United States Congress as follows:

"By enrolling thousands of people within specified 'limited time' enrollment periods, the companies within the National Liberty group are able to eliminate the cost of investigating policyowners individually. These additional savings are then passed along to policyowners in the form of lower premiums and increased benefits. . . . With the highest public interest at heart, the National Liberty Corporation group of companies combines reliability and quality of service with noteworthy price advantages. It is to be commended on its leadership and vision in this field of human welfare."

Nationally known and respected.

This is the kind of outstanding protection you may have seen in *Reader's Digest*, *Parents*, *National Geographic*, and other leading publications. The special plans offered by the National Liberty Corporation group of companies are today helping policyowners in all 50 states — and many foreign countries — paying benefits at the rate of more than \$1,500,000 a month. In addition, our Company has a RECOMMENDED rating from *Best's Insurance Reports*, one of the foremost insurance authorities in the nation.

Here are your low rates.

No matter what your age or occupation, no matter how large your family, your first month costs only 25¢. Then you may continue at these low rates for each adult:

Age at Enrollment	Monthly Premium per Adult
16-44	only \$2.95
45-49	only \$3.45
50-54	only \$3.95
55-74	only \$4.45
75 and over	only \$4.95

To cover all your unmarried dependent children from one month through 18 years, add only \$1.55 monthly. Newborn children are covered automatically at the age of one month — at no additional cost.

Note: The regular monthly premium shown here (for age at time of enrollment) will not automatically increase as you pass from one age bracket to the next . . . and can never be changed unless there is a general rate adjustment, up or down, on all policies of this type in your entire state.

Act now—"later" may be too late.

Time is precious—so act quickly. Get your Enrollment Form into the mail today. Once you or someone in your family is hospitalized by an accident, it will be too late to buy the protection you need at any cost. The time to act is now . . . before anything happens!

25¢ ENROLLMENT FORM ON BACK PAGE MUST BE MAILED BY MIDNIGHT OF DATE SHOWN. THE SOONER YOU MAIL IT, THE SOONER YOUR PROTECTION STARTS.

12 QUESTIONS AND ANSWERS

about this cash plan from the Accident Division of National Home Life Assurance Company

1. How much will my policy pay me when I go to the hospital?

You'll receive benefits at the rate of \$1,000.00 a month (\$33.33 a day) whenever you or your covered spouse are hospitalized . . . \$700.00 a month when you are 65 or over for the first three months you are hospitalized and \$1,000.00 a month thereafter while you remain hospitalized . . . \$500.00 a month whenever a covered child is hospitalized . . . \$3,000 a month if you and your covered spouse (both under age 65) are hospitalized at the same time.

2. May I enroll if I am 65 or over?

Yes. There is no age limit. And when you are 65 or over, you collect at the rate of \$700.00 a month for the first three months you are hospitalized and \$1,000.00 a month thereafter while you remain hospitalized.

3. Does my policy pay other cash benefits?

Yes. Up to \$6,000.00 at the rate of \$500.00 a month when your doctor has you employ a full-time registered nurse in your home after a hospital stay of at least three days. You must employ the nurse within seven days of leaving the hospital, and coverage continues for as long as you were confined—up to 12 full months. Plus up to \$2,000.00 for complete accidental loss of limbs or eyesight.

4. When do all these cash benefits begin?

Your cash benefits begin the very first day of hospitalization and continue for as long as hospitalization lasts—even for life, if necessary.

5. Do I have to pay tax on this money or account for it to anyone?

No. Every dollar you receive is tax-free. All your cash benefits are paid direct to you (not the hospital or the doctor) in addition to whatever other insurance you may have . . . Blue Cross Hospitalization Plans, Blue Shield Medical Plans, Workmen's Compensation, even Medicare, if you are 65 or over. Spend this cash any way you see fit.

6. What if I am hospitalized for a long time and can't pay my premiums?

Should you—the policyholder—be hospitalized for 8 consecutive weeks or more, National Home will PAY ALL PREMIUMS that come due for you and all covered members of your family while you are confined to the hospital beyond the initial 8-week period. And your protection continues just the same as if you were paying the premiums yourself. This Waiver-of-Premium benefit continues for as long as you are hospitalized, even for life, if necessary!

7. Can my policy be cancelled?

No. As long as you pay your premiums, your policy can never be cancelled for any reason . . . no matter how many claims you have or how old you become or for any other reason whatsoever. Your policy contains a Guaranteed-Renewable-for-Life clause. Only you can cancel your protection, if you wish.

8. Is any condition excluded from my policy?

Your policy covers every kind of accident . . . everywhere in the world . . . 24 hours every day. The only exclusions are hernia; injuries caused by war, or any act of war; participation in any speed contest or professional athletics; or any intentionally self-inflicted injury while sane or insane.

9. Am I covered in all hospitals?

You are covered in any hospital or nursing home, or convalescent facility.

10. How much does my first month cost? How much after that?

No matter what your age or occupation, no matter how large your family, your first month's protection costs only 25¢. Then you may continue at these low monthly rates for each adult: \$2.95 ages 16-44, \$3.45 ages 45-49; \$3.95 ages 50-54, \$4.45 ages 55-74, and \$4.95 age 75 or over. To cover all your dependent children one month through 18 years of age, add only \$1.55 monthly. And please note: The regular monthly premium shown here (for age at time of enrollment) is the same low premium you will continue to pay. It will not automatically increase as you pass from one age bracket to the next . . . and can never be changed unless there is a general rate adjustment, up or down, on all policies of this type in your entire state. Naturally, at these low rates, we can issue you only one policy of this type.

11. How does the Money Back Guarantee work?

When you receive your policy, examine it carefully in the privacy of your own home. If for any reason you are not completely satisfied, return it within fifteen days, and we will promptly refund your money. Meanwhile, you will be fully protected while making your decision.

12. How do I enroll?

Just complete the simple Enrollment Form on the back page. Then mail your Form with 25¢ for your first month's coverage to: National Home, Valley Forge, Pa. 19401.

For first month's protection, mail Enrollment Form below with **25¢**
before Midnight, Tuesday, December 14, 1971, to get
1970 Payment .40 per 1.00
1969 .68 per 1.00

\$1,000.00-A-MONTH TAX-FREE CASH

when you go to the hospital—even for life, if necessary

PAYS YOU \$1,000.00

a month each time an accident hospitalizes you or your covered spouse. Pays you \$500.00 a month when a covered child is hospitalized. Coverage starts *very first day* you are hospitalized and continues for life, if necessary.

PAYS YOU \$700.00

a month for first 3 months when you are 65 or over, and \$1,000.00 a month while you remain in the hospital thereafter... *in addition to whatever benefits you receive from Medicare.*

PAYS YOU \$3,000.00

a month if accident hospitalizes covered husband and wife (both under age 65) at the same time. You collect \$3,000.00 a month while both are hospitalized... *even for life, if necessary.*

PAYS UP TO \$6,000.00

at the rate of \$500.00 a month when your doctor has you employ a full-time registered nurse to care for you at home when you leave

the hospital, and coverage continues for as long as you were confined—up to 12 full months.

PAYS YOU UP TO \$2,000.00

for complete accidental loss of limbs or eyesight.

PAYS ALL CASH TO YOU

not to doctor or hospital. Use it any way you see fit!

GUARANTEED RENEWABLE FOR LIFE

National Home guarantees never to cancel your protection no matter how old you become... *or how many claims you have. Only you can cancel.*

LICENSED BY THE STATE OF ALABAMA

© Copyright 1971 National Liberty Corporation

HERE'S ALL YOU DO TO RECEIVE YOUR POLICY:

1. Complete this brief
2. Cut out along dotted line.
3. Enclose Form with 25¢ in reply envelope inside and mail to: NATIONAL HOME, Valley Forge, Pa. 19481

OFFICIAL ENROLLMENT FORM

OFFICIAL ENROLLMENT FORM FOR THE HOSPITALIZATION INDEMNITY ACCIDENT PLAN
NATIONAL HOME LIFE ASSURANCE COMPANY
An Old Line Legal Reserve Company of St. Louis, Missouri
ADMINISTRATIVE OFFICE: VALLEY FORGE, PENNSYLVANIA 5-1513-8-03

Name: MR. _____
(Please Print) MISS _____ First _____ Middle Initial _____ Last _____

Address _____ Street or RD# _____

City _____ State _____ Zip _____

Date of Birth _____ Month _____ Day _____ Year _____ Age _____ Sex ☐ Male ☐ Female ☐

Occupation _____
☐ Check here if you want coverage for your entire family and list all dependents to be covered under this Plan. (DO NOT include name that appears above. Use separate sheet if necessary.)

NAME (Please Print)	RELATIONSHIP	SEX	DATE OF BIRTH			AGE
			MONTH	DAY	YEAR	
1						
2						
3						
4						
5						

I hereby enroll in National Home's Hospital Accident Plan and am enclosing the first month's premium to cover myself and any others listed above. I understand that this Policy will become effective when issued and that any injury sustained after the Effective Date of this Policy will be covered.

Signature X _____ Date _____

NMA-15 _____ NHIS-1169

MAIL THIS ENROLLMENT FORM BEFORE MIDNIGHT, DEC. 14, 1971

A1463

1513

MONEY-BACK GUARANTEE

We will send your National Home policy by mail. Examine it carefully in the privacy of your own home. Show it, if you wish, to your own insurance agent, doctor, lawyer or other trusted advisor. If you decide, for any reason, that you don't want to continue as a member of this plan, return the policy within 15 days of the date you receive it, and we will promptly refund your money. Meanwhile, you will be fully protected while making your decision.

T. Robert Willett
PRESIDENT
National Home Life Assurance Company



National Home Life Assurance Company
a division of National Liberty Corporation

Adm. Offices: Valley Forge, Pennsylvania

This policy is underwritten by National Home Life Assurance Company, an old line legal reserve company of St. Louis, Missouri. National Home is licensed by your state and carries full legal reserves for the protection of all policyowners.

Established 1920—
Over 50 Years of Reliable Service

NATIONAL LIBERTY CORP.
Valley Forge, Pa., May 25, 1972.

Re: National Home Life Assurance Company—Modal Premium Payments

DEAN SHARP, Esq.,
Senate Subcommittee on Antitrust and Monopoly,
Room 104 Senate Annex, Washington, D.C.

DEAR MR. SHARP: You have inquired with respect to the current premium payment modes elected by holders of National Home's mass merchandised accident and health policies. Our estimate is as follows:

Monthly, 37%; quarterly, 26%; semiannual, 13%; annual, 24%.

Very truly yours,

DONALD D. KENNEDY, JR.

NATIONAL LIBERTY (ALL MASS MERCHANDISED ACCIDENT AND HEALTH BUSINESS)
BUSINESS SOLD IN 1960

Policy year	Policies sold in force at end of policy year—			Earned premiums	Incurred claims	Loss ratio ¹ (percent)	Number of incurred claims
	Beginning	End	Year				
1.....	0	12,353	1960	215.4	85.5	39.7	532
2.....	12,353	11,531	1961	858.9	317.9	37.0	1,876
3.....		10,529	1962	791.1	375.0	47.4	2,339
4.....		9,413	1963	716.6	428.3	59.8	2,485
5.....		8,354	1964	626.8	383.8	61.2	2,195
6.....		7,589	1965	553.3	382.6	69.1	2,126
7.....		6,543	1966	488.0	386.4	79.2	1,955
8.....		5,982	1967	427.9	342.8	80.1	1,746
9.....		5,512	1968	410.4	354.5	86.4	1,743
10.....		5,092	1969	393.7	316.1	80.3	1,567
11.....		4,727	1970	366.7	280.4	76.5	1,494
Total.....				5,848.8	3,653.2	62.5	
12.....	4,727	3,800	1971	346.4	² 164.4		² 897

BUSINESS SOLD IN 1961

1.....	0	49,087	1961	1,344.9	548.1	40.8	3,415
2.....	49,087	43,277	1962	3,524.1	1,351.8	38.4	7,737
3.....	43,277	36,986	1963	3,082.0	1,550.8	50.3	8,607
4.....	36,986	31,827	1964	2,560.9	1,485.3	58.0	9,461
5.....		28,350	1965	2,209.4	1,335.2	60.4	7,263
6.....		24,450	1966	1,913.7	1,278.5	66.8	6,666
7.....		22,263	1967	1,674.2	1,198.0	71.6	6,054
8.....		20,375	1968	1,591.2	1,161.3	73.0	5,672
9.....		18,749	1969	1,523.3	1,126.4	73.9	5,378
10.....		17,306	1970	1,414.1	1,050.7	74.3	4,973
Total.....				20,837.8	12,086.1	58.0	
11.....		14,117	1971	1,332.2	² 564.7		² 3,006

BUSINESS SOLD IN 1962

1.....	0	64,181	1962	2,290.2	1,013.9	44.3	6,044
2.....	64,181	53,908	1963	4,353.8	1,613.0	37.0	9,983
3.....	53,908	44,445	1964	3,515.4	1,505.6	42.8	9,034
4.....	44,445	39,313	1965	2,957.5	1,563.2	52.9	8,672
5.....	39,313	33,899	1966	2,551.1	1,424.3	55.8	8,672
6.....		30,765	1967	2,227.0	1,330.7	59.8	6,989
7.....		28,163	1968	2,132.4	1,291.6	60.6	6,645
8.....		25,956	1969	2,051.4	1,262.4	61.5	6,344
9.....		24,017	1970	1,913.0	1,186.6	62.0	5,795
Total.....				23,991.8	12,191.3	50.8	
10.....		19,792	1971	1,808.6	² 701.7		² 3,658

**NATIONAL LIBERTY (ALL MASS MERCHANDISED ACCIDENT AND HEALTH BUSINESS)
BUSINESS SOLD IN 1960**

Policy year	Policies sold in force at end of policy year—			Earned premiums	Incurred claims	Loss ratio ¹ (percent)	Number of incurred claims
	Beginning	End	Year				
BUSINESS SOLD IN 1963							
1-----	0	47,059	1963	1,927.5	720.5	37.4	5,417
2-----	47,059	36,734	1964	3,164.7	956.6	30.2	6,809
3-----	36,734	31,159	1965	2,560.6	917.4	35.8	6,070
4-----	31,159	26,038	1966	2,146.0	867.9	40.4	5,408
5-----	26,038	23,104	1967	1,840.1	807.8	43.9	4,865
6-----	23,104	20,730	1968	1,712.9	751.9	43.9	4,407
7-----	20,730	18,837	1969	1,612.8	730.5	45.3	4,152
8-----	18,837	17,241	1970	1,487.7	695.4	46.7	3,737
Total-----				16,452.3	6,448.0	39.2	
9-----	17,241	13,968	1971	1,396.2	2 432.6		2 2,402

BUSINESS SOLD IN 1964							
1.....	0	34,282	1964	1,103.8	351.2	31.8	2,791
2.....		26,498	1965	1,977.0	534.7	27.0	4,120
3.....		21,324	1966	1,577.0	478.6	30.2	3,508
4.....		18,484	1967	1,325.3	436.7	33.0	3,020
5.....		16,482	1968	1,217.1	411.8	33.8	2,709
6.....		14,800	1969	1,146.4	414.5	36.2	2,558
7.....		13,411	1970	1,061.7	425.7	40.1	2,360
Total.....				9,408.3	3,053.2	32.5	
8.....		10,763	1971	996.1	2 232.6		2 1,473

BUSINESS SOLD IN 1965							
1.....	0	67,809	1965	2,223.7	589.2	26.5	6,748
2.....		43,861	1966	4,264.5	1,176.5	27.6	10,179
3.....		34,049	1967	3,075.6	1,034.9	33.6	8,064
4.....		28,390	1968	2,588.7	921.5	35.6	6,666
5.....		24,643	1969	2,310.2	891.7	38.6	5,839
6.....		21,710	1970	2,080.3	782.4	37.6	4,979
Total.....				16,543.0	5,396.2	32.6	
7.....		17,083	1971	1,901.4	2 475.6		2 3,180

BUSINESS SOLD IN 1966							
1.....	0	69,938	1966	3,417.8	1,371.0	40.1	9,091
2.....		49,233	1967	5,393.6	1,906.6	35.3	11,876
3.....		40,027	1968	4,334.0	1,715.7	39.6	9,648
4.....		34,689	1969	3,927.4	1,773.1	45.1	9,285
5.....		30,634	1970	3,577.9	1,678.5	46.9	8,460
Total.....				20,650.7	8,445.0	40.9	
6.....		22,940	1971	3,298.3	2 1,024.3		2 5,401

BUSINESS SOLD IN 1967							
1.....	0	70,205	1967	3,451.9	1,444.7	41.9	8,922
2.....		51,725	1968	5,245.6	1,887.9	36.0	11,470
3.....		43,694	1969	4,477.5	1,852.1	41.4	9,943
4.....		38,128	1970	4,018.3	1,983.1	49.4	9,978
Total.....				17,193.3	7,167.8	41.7	
5.....		28,259	1971	3,728.7	2 1,211.0		2 6,362

NATIONAL LIBERTY (ALL MASS MERCHANDISED ACCIDENT AND HEALTH BUSINESS)
BUSINESS SOLD IN 1960

Policy year	Policies sold in force at end of policy year—			Earned premiums	Incurred claims	Loss ratio ¹ (percent)	Number of incurred claims
	Beginning	End	Year				
BUSINESS SOLD IN 1968							
1-----	0	87,584	1968	3,336.7	1,310.7	39.3	8,384
2-----		58,979	1969	6,213.5	2,007.2	32.3	12,651
3-----		46,207	1970	4,601.8	1,940.5	42.2	11,180
Total-----				4,152.0	5,258.4	37.2	
4-----		32,380	1971	3,848.5	² 1,181.6		² 7,004
BUSINESS SOLD IN 1969							
1-----	0	162,292	1969	6,486.6	2,163.0	33.3	15,627
2-----		103,708	1970	10,863.7	3,443.8	31.7	24,454
Total-----				17,350.3	5,606.8	32.3	
3-----		67,103	1971	8,024.2	² 2,036.9		² 14,145
BUSINESS SOLD IN 1970							
1-----	0	321,626	1970	10,498.2	3,843.3	36.6	31,581
2-----		180,539	1971	20,540.9	² 3,977.5		² 34,150
Grand total-----				172,926.5	71,149.3	41.1	

¹ Guaranteed renewable reserve not included—loss ratios understated by that amount.

² Claims data incomplete in 1971 due to lag in filing claims.

NATIONAL LIBERTY GROUP

National Liberty sells a mass merchandise hospital indemnity policy, the most popular of which is designated as NH-10. In 1970 the company issued policies providing for first day coverage (i.e., from the first day of confinement in the hospital) and a 3-day elimination period policy. During 1971 the policy was issued for first day coverage, 3-day elimination period and 5-day elimination period. The elimination period applies only with respect to sickness and not accident coverage.

In 1970 this company sold slightly more policies with the 3-day elimination period than with first day coverage. In 1971 the company sold substantially more 5-day elimination period policies than either 3rd day or first day coverage. (Recent studies have concluded that the average time spent in hospitals is a 7-day stay.) This company, in addition to the hospital waiting period, excludes from coverage those pre-existing conditions for a period of two years; i.e., any illness or symptoms thereof which have been incurred prior to taking out the policy would not be covered by the policy.

The average claim which this company pays is in the amount of \$124 despite their advertisement of \$600 a month tax free cash. The average policy premium is \$70. Of the policies issued in 1970 upon which claims were made, approximately 15,000 were paid while approximately 12,500 were rejected. Over half of those rejected were rejected by virtue of the fact that there was a pre-existing condition in effect. Another 2,000 were rejected on the basis that there was not sufficient hospital confinement, and another 1,700 were rejected because there was not coverage afforded.

In 1971 for those policies issued in 1970, approximately 29,000 claims were paid and approximately 16,000 claims were rejected. Of those 16,000 rejected, 5,000 were rejected for preexisting conditions; 3,000 were rejected for insufficient confinement; 3,000 were rejected for lack of coverage; and approximately 2,800 were rejected by reason of duplicate claims which was explained to mean that probably the doctor or hospital as well as the policyholder filed claims.

In addition to the question of whether or not National Liberty is making what can be termed excessive profits, the question is whether or not resources are being wasted by the public for "health protection." As can be seen from the memorandum regarding the policyholder survey, this company deals mainly with elderly, low income, meagerly educated people. The payout benefit appears to be extremely small—and it appears that many buy this policy in hopes of getting protection which is not there when they need it.

The following is a profile of the types of policyowners to which National Liberty sells their health policy. It is taken from the Policyowner Surveys of 1968 and 1971. This survey has been obtained under an agreement with National Liberty that, if necessary, we could question their witness on the survey including reading quotations from the survey; but we would not publish the survey in whole and would not make it a part of the public record. The reason for this is that the company claims that they spent \$100,000 for the survey and if published in toto would reveal the type of market which they are aiming at to their competitors.

1. (a) National Liberty's "current appeal is to those with a low family income . . ." (See page iv, 1971 Policyowners Survey—POS.)

(b) "Most policyowners have family incomes less than \$8,000 because of the large number of retired policyowners." (Page i, POS.)

(c) "A larger proportion of policyowners than the U.S. population are in the lower income brackets; i.e., income below \$5,000. Comparison with 1968 policyowners shows that the lower income and upper income policyowners have been retained, while the middle income policyowners have been lost. An entertained hypothesis for this bimodal behavior might be that low income persons view the product as necessary coverage, higher income persons as inexpensive coverage, and middle income persons as too expensive for the probability of making a claim on the policy." (Page 6, POS.)

2. (a) "Most policyowners are over 50 years of age." (Page i, POS.)

(b) "Most all low family income policyowners are over 55 years of age with twice as many females in this classification as males."

"Most policyowners have only a high school education or less, but 33% have completed some college or more. This is especially true in the younger and older age groups." (Page i, POS.)

(c) "An upper age policyowner is more likely to be female with an income under \$5,000; whereas a lower age policyowner is more likely to be male with an income over \$8,000." (Page ii, POS.)

THE USE OF FEAR TO SELL POLICIES

1. "Males are difficult to maintain as policyowners over time. Policyowner marketing must accentuate the importance of not leaving their families without protection. Ideas such as 'Who will pay the bills when you are in the hospital?' should be conveyed." (Page iv, POS.)

2. ". . . a larger proportion (of policyowners) than the U.S. population are widowed, divorced or separated. This indicates that appeal has been to those who are not immediately supported by a spouse . . . future ad copy should emphasize the necessity of coverage, especially when not immediately supported by a spouse." (Page 6, POS.)

3. "Upper age bracket policyowners are more heavily female than male . . . females at this age may feel more insecure than males concerning health costs and hence purchase the coverage . . . The notion of inexpensive coverage should be directed to males with the notion of essential coverage directed to females . . . Ad copy should accentuate that coverage is excellent supplemental coverage to Medicare to the older female who has a lower income." (Pages 8 and 9, POS.)

DO POLICYOWNERS UNDERSTAND WHAT THEY ARE BUYING?

In considering this aspect one should keep in mind the type of advertising which this company uses; i.e., pay \$600 a month. In fact, the average claim paid is \$124 and about 50% of claims filed within the first two years of becoming a policyowner are rejected for pre-existing conditions.

On pages 24 and 25 of the survey, it requested certain information from policyowners with respect to types of insurance which the policyowners presently have. The conclusion is that the results may not have been conclusive because the policyowners may not have understood what type of insurance they presently

have; i.e., they would not know the difference between group insurance and non-group insurance. One could speculate that the reason for this high rejection of claims on the ground of pre-existing conditions was because the policyowners would not understand this factor in the insurance policy. The policy itself is confusing in this regard.

STATE OF NEW YORK, INSURANCE DEPARTMENT,
Albany, N.Y., August 25, 1972.

Hon. PHILIP S. HART,
*Chairman, Committee on the Judiciary, Subcommittee on Antitrust and Monopoly,
U.S. Senate, Washington, D.C.*

DEAR SENATOR HART: Mr. Robert E. Slater, Chairman of the Board of the National Liberty Corporation and of its insurance subsidiaries, recently testified before your Subcommittee with respect to health insurance. Without endorsing the remainder of his testimony, we want to set the record straight with reference to "New York grades companies from A+ to F in anticipated cumulative loss ratio and under this standard National Liberty Companies rate A+" and "our corporation, on the other hand, formed a new company in New York in 1971, which has an A+ rating in claims . . ." contained on page 14 of Mr. Slater's prepared text, and a similar reference to "A+ rating in New York" appearing on page 17.

Neither the New York State Insurance Department nor the State of New York rates insurance companies on any bases that would be encompassed by the A+ reference. The New York State Health Department did publish a monograph setting forth a proposed system for grading health insurance policies based on a "benefit ratio" concept and grading policies from A+ to F-. The benefit ratio referred to in that monograph concerns the proportion of the total medical expenses that would be paid for by an insurance policy for a stated common illness or medical procedure. Under the proposed grading system a policy having a 65% or better benefit ratio would rate A+.

Mr. Slater in his testimony apparently confused the cumulative loss ratio requirement for approval of policy forms by the Insurance Department in New York with the benefit ratio proposed in the Health Department's monograph. In fact, the two National Home Assurance Company's policies used in New York would rate F and F+ on the basis of the grading system proposed in the Health Department's monograph.

We would appreciate it if this letter were made a part of the transcript of your Subcommittee's hearings on health insurance.

Sincerely yours,

ROBERT J. BERTRAND,
Deputy Superintendent.

NATIONAL LIBERTY CORP.,
Valley Forge, Pa., September 5, 1972.

Mr. ROBERT J. BERTRAND,
*Deputy Superintendent, State of New York,
Insurance Department, Albany, N.Y.*

DEAR MR. BERTRAND: Thank you for your letter dated August 25, 1972, relating to our testimony before the Senate Antitrust and Monopoly Subcommittee. A copy of my July 17 letter to you bearing on our reference to rating by the State of New York of health insurance policies according to loss ratios is also enclosed.

Our testimony relied on a report dated February 3, 1972, published by William D. Witter, Inc. which report inferred that the New York State Insurance Department grades policies on the basis of loss ratios. After reviewing this analyst's report and before preparing our testimony for the Senate Antitrust and Monopoly Subcommittee, we on several occasions questioned the New York State Insurance Department to make sure that our interpretation was correct. In the absence of any reply from the Department, we assumed that our interpretation was in fact accurate.

Having read the monograph published by the New York State Health Department, I share your view that the monograph nowhere suggests a grading schedule based on loss ratios. You will understand, however, after reviewing the enclosed William D. Witter, Inc. report, why our testimony referred to grading on the basis of loss ratios.

In accordance with your request, we enclosed herewith a schedule of loss ratios for policy issue years 1963 and after. This schedule has been prepared from data compiled on the same basis as that which was used for policy issue years 1960 through 1962 appearing in Exhibit "I" on Page 14(a) of our Senate Subcommittee testimony.

Very truly yours,

ROBERT E. SLATER.

NATIONAL LIBERTY CORP.,

Valley Forge, Pa., September 5, 1972.

SENATE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY,

Senate Annex,
Washington, D.C.

(Attention: Dean Sharp, Esquire).

DEAR MR. SHARP: I enclose herewith a copy of Mr. Slater's letter bearing today's date to Deputy Superintendent Robert J. Bertrand of the New York State Insurance Department. Mr. Bertrand has raised with Mr. Slater questions relating to his testimony before the Subcommittee to the effect that the New York State Insurance Department has graded the National Liberty Group on the basis of the loss ratios of its policies. Our testimony that "New York grades companies from A+ to F in anticipated cumulative loss ratio and under this standard National Liberty Companies rate A+" (Testimony Page 14) was apparently erroneous.

Mr. Bertrand noted that the grading system was proposed by the New York State Department of Health rather than the Insurance Department of the state of New York, and that the grading system proposed was based on "benefits ratios" (percent of medical charges covered by insurance) rather than loss ratios. As Mr. Slater states in his enclosed letter to Mr. Bertrand, our testimony relied on an analyst's report published by William D. Witter, Inc. on February 3, 1972. This reliance may have been a mistake.

In any event, we want to bring to your attention the fact that our testimony relating to the grading by the New York State Insurance Department might be inaccurate although it is clear that our policies issued in New York are priced to produce cumulative loss ratios of not less than 60-65%. Of course, National Liberty Corporation has at all times wished to cooperate fully with the Subcommittee in every way, and wants the record to be clear that any misinformation contained in its testimony was entirely unintentional.

Very truly yours,

DONLD D. KENNEDY, Jr.

PEAT, MARWICK, MITCHELL & Co.,

CERTIFIED PUBLIC ACCOUNTANTS,

Chicago, Ill., January 4, 1971.

MR. BENJAMIN WEAVER,
Treasurer, National Liberty Corp.,
Valley Forge, Pa.

DEAR BEN: I am writing this letter to report on the status of adjusted earnings for National Liberty and National Home.

Natural reserve factors have been calculated for life insurance and health insurance in Valley Forge. Assumptions used are outlined in Exhibits 1-4. I have previously given one copy of these factors to Stan Sims and John Gibson. A duplicate set (Exhibits 5 and 6) is attached with this letter.

A magnetic tape with guaranteed renewable factors has been sent to Stan Sims.

Several points should be made about guaranteed renewable natural reserves:

1. The interest assumptions are the same as for guaranteed renewable St. Louis business.

2. Expenses and commission for both insurance companies are based on the 50%-20% commission scale paid by them to DeMoss Associates.

3. For 1970 National Home issues after September 1st, I understand the full acquisition expense is charged directly to National Home. Based on the level of acquisition expense, this means an expense reserve based on a 64%-20% scale

could be used. As indicated in Exhibit 3, the National Home expense reserves in 1970 issues can be adjusted (made more negative) by 11.6%, which should account for this change in acquisition expense.

Also attached is a set of factors to amortize the acquisition expense in DeMoss Associates not covered by the insurance companies. For every dollar of expense incurred in a given calendar year, these factors are the remaining unamortized expense as of each December 31. They are designed to be consistent with expected premium income over the life of health insurance business. I calculated two alternate sets of factors, depending upon whether you assume the unamortized balance increases with interest each year. This does not appear to have a significant effect on the rate of amortization.

I hope to discuss these matters with you in the near future.

Sincerely,

PEAT, MARWICK, MITCHELL & Co.,
NORMAN E. HILL, *Manager*.

EXHIBIT 1.—NATIONAL LIBERTY LIFE INSURANCE CO. AND NATIONAL HOME LIFE ASSURANCE CO.
ASSUMPTIONS USED FOR NATIONAL RESERVES GUARANTEED RENEWABLE HEALTH BUSINESS

Type	National Liberty	National Home	Presidential and World
A. Major plans:			
Hospital.....	YA	P3	SJ
Medical-Surgical.....	78	CS	SQ
Accidental Death.....			
Accident-Hospital.....	B1	B1	B1
B. Issue ages (age group):			Age used
0 to 29.....			27
30 to 39.....			37
40 to 49.....			47
50 to 59.....			57
60 up.....			67
C. Commissions (percent):			
1. First year.....			50
2. Renewals.....			20
D. Interest—Same as National Home, St. Louis:			
Year of issue: ¹		Interest rate	
1965 and prior.....	5 percent.		
1966-68.....	6¼ percent graded to 5¼ percent at end of 20 years.		
1969.....	8 percent graded to 6 percent at end of 20 years.		
E. Mortality:			
100 percent of 1955-60. Ultimate male basic table, age last birthday.			
F. Morbidity:			
1956 Intercompany study adjusted as follows:			
1. Hospital, based on National Liberty gross premium assumptions. () male, 85 percent () female, 80 percent.			
2. National Home—4th day sickness coverage—use ratio of 0.75.			
3. Reduced hospital benefit after age 65: () National Liberty, Presidential and World, 80 percent: () National Home, 60 percent.			
4. Equivalent surgical schedule: () National Liberty, \$200; () National Home; (1) male, \$280. (2) female, \$240.			
5. Medical in-hospital calls—each dollar per call equals 40 percent of the hospital claim cost per dollar, per day.			
G. Lapse Rates—Same as National Home, St. Louis:			
Year:			Lapse rates (percent)
1.....			30
2.....			20
3.....			15
4.....			11
5 and after.....			Linton B
H. Premium taxes:			
1 percent per year for all plans.			

¹ All issues for National Home, Presidential and World included with the 1969 assumptions.

EXHIBIT 2

NATIONAL LIBERTY LIFE INSURANCE COMPANY AND NATIONAL HOME LIFE
ASSURANCE COMPANY

TEMPORARY MODIFICATIONS, DECEMBER 31, 1970 (DUE TO TIME LIMITATIONS)

A. Presidential & World—use National Home factors.

B. Hospital reserves ages 57 and 67—due to rounding problems, reduce benefit reserve factors and increase expense reserve factors slightly. The result is that

each reserve is approximately \$5,000 incorrect, although the total reserve (the net of a positive benefit reserve and a negative expense reserve) should still be correct.

C. Use hospital reserves in place of accident—hospital reserves, with a possible manual adjustment.

EXHIBIT 3

NATIONAL LIBERTY LIFE INSURANCE CO. AND NATIONAL HOME LIFE ASSURANCE CO.

Derivation of acquisition expense as a percent of premium

A. Acquisition expense, January–September, 1970:	
De Moss Associates-----	\$15,051,000
National Home-----	1,925,000
Total -----	16,976,000
B. Estimated acquisition expense, calendar year 1970-----	22,500,000
C. Estimated first year premiums issued—	
1. First year premiums 1969:	
(a) National Liberty-----	8,800,000
(b) National Home-----	11,600,000
Total -----	20,400,000
2. Ratio of acquisition expense 1970/1969 equals 22.5 million divided by 12.8 million-----	1.75
3. Estimated first year premiums 1970-----	35,000,000
D. Ratio of acquisition expense to first year premiums (percent)---	64
E. For National Home, effective acquisition expense for 1970: 8 months at 50 percent; 4 months at 64 percent-----	54 $\frac{2}{3}$
F. Adjusted factor for natural expense reserves for 1970 National Home issues equals 54 $\frac{2}{3}$ percent minus 20 percent divided by 50 percent minus 20 percent equals (percent)-----	11.6

EXHIBIT 4

NATIONAL LIBERTY LIFE INSURANCE CO. AND NATIONAL HOME LIFE ASSURANCE CO. ASSUMPTIONS
USED FOR NATURAL RESERVES ON LIFE INSURANCE

A. Major plans, all companies:	
1. Type and issue years:	
Ordinary life (old), 1968 and prior-----	\$143-1000
Ordinary life (new), 1969 and 1970-----	\$163-1000
College and career, all years-----	\$161-5001
2. Plans included under major plans: (a) Ordinary life, all whole life and endowment plans; (b) College and career, college plans and all term plans.	
B. Issue ages (age group and age used):	
0 to 34-----	30
35 to 44-----	40
45 to 54-----	50
55 and above-----	60
C. Commissions, none.	
D. Per policy expenses:	
1. 1st year, \$30 per policy.	
2. Renewal, \$5 per policy.	
E. Premium taxes:	
1. 1968 and prior issues, 1 percent.	
2. 1969-70 (including all term), 2 $\frac{1}{2}$ percent.	
F. Interest:	
Year of issue and interest rate (percent):	
1968 and prior-----	5
1969-70-----	5 $\frac{3}{4}$
All term-----	$\frac{7}{8}$
G. Mortality: 100 percent of 1955-60 ultimate male basic table, age last birthday.	
H. Lapse rates: Linton C.	
I. Average size policy:	
1. Ordinary life (old)-----	\$1,600
2. Ordinary life (new)-----	2,600
3. Term-----	10,000

¹ 5 $\frac{3}{4}$ percent graded to 5 $\frac{1}{4}$ percent at end of 20 years.

² $\frac{7}{8}$ percent graded to 6 percent at end of 20 years.

EXHIBIT 5A

NATIONAL LIBERTY LIFE INSURANCE CO. AND NATIONAL HOME LIFE ASSURANCE CO.

Format for guaranteed renewable natural reserve run

Information :	Column
Duration -----	1
Midterminal Natural Reserves—Benefits ¹ -----	2
Midterminal Natural Reserves—Expenses ¹ -----	3
Midterminal Natural Reserves—Total ¹ -----	4
Natural Reserve Annual Premium—Benefits-----	5
Natural Reserve Annual Premium—Expenses-----	6
Natural Reserve Annual Premium—Total-----	7
Gross Annual Premiums-----	8
Terminal Natural Reserves—Benefits-----	9
Terminal Natural Reserves—Expenses-----	10
Terminal Natural Reserves—Total-----	11

¹ Used in calculating calendar year adjusted earnings.

DEMOSS ASSOCIATES—ASSUMPTIONS USED FOR AMORTIZATION OF ACQUISITION EXPENSES

- A. Expenses—Per each dollar.
- B. Interest accumulating on unamortized balance :
 - 1. Alternative 1—None.
 - 2. Alternative 2—8 percent graded to 6 percent at end of 20 years.
- C. Year and Lapse Rates :
 - 1. 30 percent ; 2, 20 percent ; 3, 15 percent ; 4, 11 percent ; 5 and after, Linton B.
- D. Average age at issue—47.

WHY DO WE AMORTIZE ACQUISITION COSTS OVER 20 YEARS?

(By W. Benjamin Weaver, Vice President, Finance National Liberty Corp.)

As of December 31, 1970, National Liberty revised its method of financial reporting to conform with the accounting principles set forth in *Audit Guide For Life Insurance Companies*, which was released as an exposure draft in December 1970 by the American Institute of Certified Public Accountants. Because we were one of the first companies to adopt these principles, and because the adaptation of these principles has significantly changed our financial statements, this memorandum is prepared to explain the theory behind these adjustments, how the adjustments were calculated, and why we think the numbers produced by this method conservatively state the results of operation and the financial condition for National Liberty Corporation.

This new method of accounting basically recognizes three points. First of all, it recognizes the need for matching cost with revenue. Secondly, it recognizes that insurance is, in fact, a business of long term contracts, and thirdly, it recognizes that the management of the insurance company must know what it's doing when it makes the various assumptions required for the establishment of premium loss in the year in which such deviation occurs.

In order to clarify the above, let's consider the basic function of an insurance company. An insurance company sells coverage against possible loss for a certain fixed premium rate. This premium rate is designed to produce a cash flow which together with expected income will be sufficient to cover expected claim cost, expected cost of acquiring the business, expected cost of issuing and administering the business and, if the company is a stock company, the expected profit margin. These expectations are based upon actuarial and statistical summaries of the past history, modified where appropriate, to the company's own experience. The insurance company is relatively confident that this past history will be the experience in the future because of the "power of big numbers," i.e. if statistics indicate that a person of a certain age has a life expectancy of 40 more years, the probability of one person living exactly 40 years is remote, but the probability of 100,000 people of the same age living an average of 40 more

years is quite good. Hence, many of the variables the insurance company has to contend with when establishing premium rates are significantly tempered by this "power of big numbers."

Because insurance is, in fact, a business of long term contracts, and because National Liberty, unlike most other companies, spends all its acquisition cost at the time the business is placed on the books, one of the most critical assumptions in our company is the persistency assumption. This persistency assumption is based upon the actuarial summaries of the past for our type of business. It recognizes that at each premium due date a certain percentage of policyholders will pay renewal premiums. Hence, in order to match cost with revenue, the acquisition cost must be capitalized and written off as the expected revenue cycle, which takes into account the persistency assumption, is generated in the form of premium income.

In attempting to apply this persistency assumption to the capitalization and amortization of our acquisition cost, we recognized that because we had several hundred advertising campaigns per year, it would be an administrative impossibility to calculate this capitalization and amortization on a policy by policy basis. Hence, we sought the help of the actuarial staffs of both Peat, Marwick, Mitchell & Company and Lybrand, Ross Bros. & Montgomery.

The actuaries first reviewed our method of establishing premium rates, and noted that we used the Linton B table for this persistency assumption. They next reviewed our historic persistency statistics which were accurate for the last 5 years. These statistics indicated that, particularly in the first two years, our actual experience was worse than that expected in the Linton B table, but that the next three years were very close to the expectations of the Linton B table. The actuaries then developed a table that modified the Linton B table for our actual experience for the first 5 years.

In order to use these persistency statistics to develop an amortization schedule, we then had to select an average age of our insureds at time of issue. Recent experience indicated that this average age was 52, but in order to be conservative, we advanced this assumption to issue age 57. This produced an amortization schedule which was on a declining balance basis and extended for 43 years with an unamortized asset at the end of the 20th year being about 15% of the original acquisition cost, and in the 43rd year, the amortization would have been less than .01%.

Again, to be conservative, we elected to arbitrarily shorten the amortization period to 20 years by spreading the amortization that would have occurred after the 20th year on a pro-rata basis over the first 20 years. Hence, we wind up with a declining balance basis of amortization which does extend for 20 years, whereby approximately 12% of the asset is amortized in the first year, and approximately 50% of the asset has been amortized after 7 years.

Having now calculated and capitalized the acquisition cost and developed the related amortization, it next became necessary to look at our liability for future benefits to policyholders. This liability, for statutory reporting purposes, had been calculated on a 2 year preliminary term basis which basically recognizes the fact that high acquisition costs are incurred in the first policy year and, accordingly, no liability is created until the policy has been in force at least 2 years.

Since the cost of acquiring the business has been capitalized under the new formula, it became necessary to start creating this liability fund immediately. This liability fund is created on the net level premium basis and it does take into account the best estimates of the company at the time the policy was sold as to interest earnings, morbidity, mortality and persistency.

To explain these latter points in a little more detail, let's consider the interest assumption. For statutory reporting purposes, this reserve is calculated on the basis that the reserve funds will be invested at approximately 2½% interest, whereas when the policy was sold, a higher interest rate, say 5½%, was assumed. Hence, for generally accepted accounting purposes, when calculating this reserve, we assume that the reserve funds will be invested at 5½%. As a point of additional information, the interest earnings, the morbidity, mortality and persistency assumptions, seem in our business to almost counterbalance each other to the extent that the charge to earnings is very nominal because of these adjustments, but there is a very material increase in expense because of the conversion from 2 year preliminary term to net level reserving.

Of course, deferred federal income taxes are recognized in exactly the same fashion as would occur in any other industry.

At National Liberty, these three adjustments, the increase in deferred acquisition cost, the increase in the liability for policyholder reserves, and the increase in deferred federal income taxes, are the principal adjustments that are required in converting to generally accepted accounting principles. We believe that the method that we have used does properly match cost with revenue and that we have built a good number of conservative factors into our calculation.

To make sure that we had a method that would fairly state our results of operation, and equally important, be a method by which our management could be measured year by year, we employed not one, but two, of the largest public accounting firms in the country—Lybrand, Ross Bros. & Montgomery and Peat, Marwick, Mitchell & Company—to assist us in developing this method and audit the results that were produced. In their opinion, the financial statements produced by this method fairly present our financial picture in accordance with generally accepted accounting principles.

I'm sure at first glance many people will look at our results with a jaundiced eye to the extent that 50% of our assets are in this deferred policy acquisition cost account, and this represents approximately 150% of our net worth. We could attempt to minimize the importance of this deferred asset account by pointing out that the only way this asset would become completely worthless would be for our entire policyholder file to simultaneously lapse at the balance sheet date, and if that virtually impossible situation were to occur, then there would be a simultaneous release of the liability item for policy reserves and deferred taxes, which at December 31, 1970 were equal to approximately 87% of the asset item "Deferred Policy Acquisition Costs."

It would seem to me, however, to be more germane to recognize that the reason our deferred policy acquisition cost is so significant on our balance sheet is because we are in the business of selling insurance on a profitable basis. We, as management, don't rely on fancy bookkeeping methods to evaluate the profitability of our investment in new business, but rather we use the discounted cash flow basis of measuring the rate of return on a projected investment. This discounted cash flow basis does take into account the fact that insurance is essentially a business of long term contracts and we do, in fact, use a 20 year period for projecting premium collections under this rate of return calculation.

We at National Liberty are delighted that we finally have a method of reporting earnings to our shareholders that, in our opinion, does match cost with revenue, and is a method to which our outside auditors can provide certification. Consider the predicament that we have found ourselves in in the past, where we really had three methods of reporting earnings. First, there was the statutory method, which was basically a liquidating concern type of reporting, which used the basic assumption that all policies lapsed at the balance sheet date, and which really didn't match cost with revenue.

Secondly, we had the method that we use for reporting for SEC purposes, which provided for the capitalization and amortization of acquisition costs over a three year period. This three year period was determined by compromise rather than based upon the facts, and really didn't match cost with revenue.

Thirdly, in order to attempt to provide some method of reporting earnings which came close to matching cost with revenue, we also reported to our shareholders what we called the investment analyst basis. This basis had two basic flaws. First of all, it was based upon some arbitrary calculations which, as history indicates, did come fairly close to matching cost with revenue as it is now developed under the generally accepted accounting principles' basis, but because of these arbitrary assumptions, we were unable to get independent outside certification. This method also had an inherent flaw in that it seemed every investment analysis had his own method of developing adjusted earnings, which certainly created quite a credibility gap in the investment community.

There has been very limited data available as to what competition in the insurance industry is doing, or will do, in adopting this method, but we can see in one prospectus that one company is using an amortization period of 20 to 25 years, another company is using the natural reserve method of adjusting, which has to result in a capitalization and amortization cycle that is much longer. In our prospectus, we have attempted to take the bull by the horns and specifically state exactly what we've done and, hopefully, the above will explain why we believe this is the right approach.

I hope the above has added some clarity to our method of converting to generally accepted accounting principles, and I welcome any comments or questions that you may have regarding this conversion.

[As filed with the Securities and Exchange Commission on Aug. 26, 1971, Registration No. 2-39973]

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

AMENDMENT No. 3

TO

Form S-1

REGISTRATION STATEMENT

Under

THE SECURITIES ACT OF 1933

National Liberty Corporation
(Exact name of Registrant as specified in charter)

700,000 Shares

National Liberty Corporation Common Stock

PROSPECTUS

August 26, 1971

SMITH, BARNEY & Co., INCORPORATED

KIDDER, PEABODY & Co., INCORPORATED

No person has been authorized to give any information or to make any representation not contained in this Prospectus and, if given or made, such information or representation must not be relied upon as having been authorized. This Prospectus does not constitute an offer of any securities other than the registered securities to which it relates or an offer to any person in any jurisdiction where such offer would be unlawful. The delivery of this Prospectus at any time does not imply that the information herein is correct as of any time subsequent to its date.

PROSPECTUS

700,000 Shares

National Liberty Corporation Common Stock

Of the shares offered hereby, 500,000 shares are being sold by National Liberty Corporation (the "Company") and the remaining 200,000 shares are being sold by the shareholders named under "Selling Shareholders". The Company will not receive any of the proceeds from the sale of shares by such shareholders.

On August 26, 1971, the closing median bid price for the Company's Common Stock in the over-the-counter market as reported by the National Association of Securities Dealers' automatic quotation system was 37. See "Price Range of Common Stock".

The shares offered hereby may not be sold in New York State, except to certain institutions. For information on this restriction and for a summary of recent changes in the business and accounting practices of the Company, see "Special Considerations".

THESE SECURITIES HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SECURITIES AND EXCHANGE COMMISSION NOR HAS THE COMMISSION PASSED UPON THE ACCURACY OR ADEQUACY OF THIS PROSPECTUS, ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE

	Price to public	Underwriting discount (1)	Proceeds to company (2)	Proceeds to selling share- holders (2)
Per share.....	\$36.50	\$2.10	\$34.40	\$34.40
Total.....	\$25,556,000	\$1,470,000	\$17,200,000	\$6,880,000

Note: (1) The company and certain of the selling shareholders have agreed to indemnify the several underwriters against certain civil liabilities, including liabilities under the Securities Act of 1933. (2) Before deducting expenses estimated at \$236,000 payable by the company and \$66,100 payable by certain of the selling shareholders.

The shares of Common Stock are being offered by the several Underwriters when, as and if delivered to and accepted by them, and subject to prior sale, withdrawal of such offer without notice, approval of counsel and certain other conditions. It is expected that the shares will be ready for delivery on or about September 2, 1971.

In connection with this offering, the Underwriters may over-allot or effect transactions which stabilize or maintain the market price of the common stock of the company at a level above that which might otherwise prevail in the open market, such stabilizing, if commenced, may be discontinued at any time.

NATIONAL LIBERTY CORPORATION

National Liberty Corporation and its subsidiaries ("National Liberty Group") primarily engage in soliciting and underwriting accident and health and life insurance policies sold by mass marketing techniques rather than through agents compensated on a commission basis. The accident and health policies offered typically provide disability income coverage by payment of a fixed weekly or monthly benefit and generally are guaranteed renewable. Business is solicited principally through coupon response advertising in newspapers and other mass media. In addition, National Liberty Group makes limited use of an agency force.

In its operations, National Liberty Group makes substantial expenditures for marketing activities, principally for the purchase of newspaper space for coupon response advertising. See "Use of Proceeds" and "Insurance Operations—Marketing". These policy acquisition costs are capitalized and then written off to expense on substantially the same basis as the related premium income is expected to be received. For a description of this and other accounting practices and their effects, which are material, on the Group's reported results of operations and financial position, see "Certain Factors Affecting Accounting and Profits" and the Notes to Financial Statements referred to therein.

National Liberty Group's insurance business initially was concentrated on the sale of policies, principally through direct mailings, to persons who represented that they abstained from alcoholic beverages. In 1968, National Liberty Group began selling policies to the general public, primarily through newspaper and magazine advertising, and now directs the major portion of its marketing efforts to this broader market.

National Liberty Corporation is a holding company which conducts its business through operating subsidiaries. Insurance activities are conducted through DeMoss Associates, Inc., National Liberty Life Insurance Company and National Home Life Assurance Company. The Company is also engaged through smaller subsidiaries in computerized systems management, development and sale of computer equipment and non-insurance marketing. Approximately 81% (76% after giving effect to the offering made hereby) of the Company's outstanding Common Stock is owned by Mr. Arthur DeMoss, its president. See "Principal Shareholder".

The executive offices of the Company are located in a recently constructed office building in Frazer, Pennsylvania. Its mailing address is Valley Forge, Pennsylvania 19481, and its telephone number is (215) 647-5000.

SPECIAL CONSIDERATIONS

The Insurance Department of the State of New York has not approved the shares offered hereby for sale in New York; it does not presently accept financial statements of life insurance companies prepared on the basis of the generally accepted accounting principles described under "Certain Factors Affecting Accounting And Profits".

The following is presented to indicate certain recent changes in the business and accounting practices of the Company:

1. Gross premium income from accident and health policies has increased from \$21,349,097 in 1966 to \$46,791,736 in 1970 or by 119%. Gross income in 1970 includes approximately \$6,000,000 of premiums from reinsurance assumed, all of which were solicited by DeMoss Associates through mass marketing techniques for two unrelated insurers and reinsured by National Liberty Group. See "National Liberty Group" and "Insurance Operations—Reinsurance".

Marketing expenditures have increased from \$5,132,000 in 1966 to \$24,102,000 in 1970 or by 369%. See "Insurance Operations—Marketing".

2. National Liberty Group has changed its accounting method for 1970, and the financial information contained herein prior to 1970 has been retroactively

changed from figures previously reported. This has resulted in an increase in earnings which is reflective solely of accounting changes and is not necessarily an indication of improved operations. See "Certain Factors Affecting Accounting and Profits".

Comparative net income and net income per share utilizing the previous accounting method and utilizing the present accounting method are as follows:

	1966	1967	1968	1969	1970 ¹
Net income utilizing previous method.....	\$1,607,382.00	\$722,113.00	\$2,341,495.00	\$2,919,762.00	\$7,103,153.00
Net income per share utilizing previous method.....	.20	.09	.28	.33	.81
Net income utilizing present method.....	3,259,583.00	2,913,138.00	3,672,177.00	6,313,727.00	12,109,059.00
Net income per share utilizing present method.....	.41	.36	.44	.72	1.37

¹ Includes extraordinary items, principally gain on sale of portfolio of insurance, net of related deferred income taxes of \$4,413,087 or \$.50 per share under the previous accounting method and \$3,353,726 or \$.38 per share under the present method.

See notes (a) and (f) to consolidated statement of income of National Liberty Corp. and subsidiary companies

3. Since policy acquisition costs are capitalized and then written off as the related premium income is expected to be received, recoverability of \$63,265,347 of such costs, which had been capitalized and were unamortized as of December 31, 1970, depends upon policyholders' remaining with the Company. Policyholder persistency may be adversely affected by increases in premium rates, expansion of government health programs or other factors outside the control of the Company.

4. Prior to 1968, the Company solicited insurance primarily from persons who represented that they abstained from alcoholic beverages. Subsequently, the Company began solicitation from the general public, and as of December 31, 1970, only 44% of premium income was derived from abstainer policies.

Actual experience as to the persistency of policyholders to whom marketing is now directed is limited and therefore the Company has made certain assumptions based solely on its experience in the abstainer market in determining the amortization schedule of capitalized policy acquisition costs.

5. If the Company's assumptions with respect to persistency of insurance are not met, the present policy for amortization of acquisition costs may have to be revised. This may have an adverse effect on earnings. The Company intends to review its experience in this regard on an annual basis and will revise its amortization policy, if deemed appropriate, based upon that review so as to continue to match costs with revenues, but in no event to permit losses to be deferred.

USE OF PROCEEDS

The solicitation methods of National Liberty Group require the expenditure of substantial funds for marketing activities, primarily the purchase of newspaper space for coupon response advertising, prior to the receipt of any premium income from such expenditures. Of the net proceeds from the sale of shares offered by the Company (estimated at approximately \$16,964,000), \$7,500,000 will be used to repay bank indebtedness incurred by it to finance prior marketing expenditures of DeMoss Associates, Inc. The balance of the proceeds of \$9,464,000 will be invested in the insurance subsidiaries and used to finance part of the marketing expenditures through 1972. Marketing expenditures are currently expected to be approximately \$39,000,000 in 1971 and at least that amount in 1972, but the sums eventually expended may differ substantially from these estimates, depending primarily on the market response to various advertising expenditures and on geographic expansion or introduction of new types of policies. Although no assurance can be given with respect to future operations, the remainder of the marketing expenditures during this period is expected to be met from internally generated funds. See "Insurance Operations—Marketing" for marketing expenditures during the five and one-half years ended June 30, 1971.

Until these proceeds are so employed, they will be invested in commercial paper and other short-term securities. The current rate of return on short-term securities is lower than the Company's overall rate of return on its invested capital in 1970. No assurance can be given that the Company will have a similar overall rate of return in 1971.

CAPITALIZATION

The capitalization of the Company as of June 30, 1971, and as adjusted to give effect to the sale of the Common Stock being offered by the Company, is as follows:

	Outstanding	As adjusted
Short term bank notes ¹	\$7,500,000	None
5¾ percent convertible subordinated debentures due 1984 ²	2,000,000	\$2,000,000
Sundry other long term indebtedness.....	352,819	352,819
Total notes and long term debt (including current installments).....	9,852,819	2,352,819
Common stock, \$1 par value (12,500,000 shares authorized) ³	8,794,961	9,294,961

¹ Bear interest at the prime rate, currently 6 percent per year.

² The amount outstanding is the amount originally issued.

³ Outstanding shares exclude 92,592 shares of common stock reserved for issuance upon conversion of the convertible debentures and 149,000 shares reserved for issuance upon exercise of options granted or to be granted under the company's stock option plan. The authorized shares were increased from 7,500,000 shares to 12,500,000 shares on Apr. 28, 1971. The outstanding shares reflect a 4 for 3 stock distribution in April 1971. The company also has authorized 500,000 shares of preferred stock, \$1 par value, none of which is outstanding.

Note: National Liberty Group leases premises and data processing equipment for various terms, for which the aggregate annual rentals are approximately \$1,343,000.

DIVIDENDS

The Company has not paid any cash dividends since its incorporation and presently intends to continue to retain earnings for use in the business. The Company has, however, made stock distributions and intends to continue to consider making them, but no assurance can be given that any will be made.

For restrictions on the Company's ability to pay cash dividends and on the ability of the insurance subsidiaries to pay such dividends to the Company and the tax consequences thereof, see "Insurance Operations—Regulation", Note 5 to Consolidated Financial Statements of National Liberty Corporation and Subsidiary Companies and Note 5 to Consolidated Financial Statements of National Liberty Life Insurance Company and Subsidiary.

PRICE RANGE OF COMMON STOCK

The following table shows the high and low bid prices per share of the Company's Common Stock, as reported by the National Quotation Bureau, Inc., in the over-the-counter market since its initial public offering on July 2, 1968, as adjusted for stock distributions of 6 for 5 in 1969, 5 for 4 in 1970 and 4 for 3 in April 1971. These quotations represent prices between dealers, do not include retail mark-ups, mark-downs or commissions, and do not represent actual transactions.

	High bid	Low bid		High bid	Low bid
1968:			1970:		
Third quarter.....	107½	81½	First quarter.....	291½	21½
Fourth quarter.....	18½	10½	Second quarter.....	27½	15½
1969:			Third quarter.....	20¾	15
First quarter.....	171¼	143½	Fourth quarter.....	22¾	16¾
Second quarter.....	201½	14	1971:		
Third quarter.....	17¾	13¾	First quarter.....	36¾	21¾
Fourth quarter.....	26¼	16¼	Second quarter.....	45¾	34¼
			Third quarter (to Aug. 25).....	43	29½

Note: On Aug. 26, 1971, the closing median bid price for the company's common stock as reported by the National Association of Securities Dealers' automatic quotation system was 37.

CERTAIN FACTORS AFFECTING ACCOUNTING AND PROFITS

The financial statements included in this Prospectus have been prepared in accordance with the principles contained in the exposure draft of *Audits of Life Insurance Companies*, released by the American Institute of Certified Public

Accountants in December 1970. This exposure draft has not been adopted by the AICPA and there is no assurance that it will be adopted or that it will not be substantially revised before adoption. The exposure draft sets forth broad guidelines for matching costs with revenues for insurance companies but does not prescribe specific actuarial assumptions or methods for amortizing acquisition expenses and calculating policy reserves to be used in financial reports. Accordingly, neither the AICPA nor any committee thereof has considered or passed upon the assumptions and methods adopted by the Company. If the exposure draft is adopted in a changed form, the Company will report in accordance therewith, which could have a material adverse effect on the Company's reporting of its results of operations and financial position. If the exposure draft is not adopted, the Company intends to continue to report on the same methods presented herein.

As shown in Note (a) to the following Consolidated Statement of Income, consolidated net income is substantially higher than previously reported. Similarly, the net income of the insurance subsidiaries reflected therein is substantially higher than reported to state regulatory agencies. Such increases in net income have resulted in corresponding increases in surplus. The following are the principal areas of difference between the financial statements included herein and the financial statements reported for years prior to 1970 by the Company:

Policy Acquisition Costs.—In the financial statements included herein, policy acquisition costs (largely expenditures for coupon response advertising) are capitalized and then written off to expense on substantially the same basis as the related premium income is expected to be received, as more fully described in the next two paragraphs. The amount of capitalized policy acquisition costs as of December 31, 1970 was \$63,265,347. The period over which costs are written off is determined by taking into account persistency expectations and the age of the policyholder at time of policy issue. For the bulk of the existing accident and health business, these costs are written off over a twenty-year period on a declining balance method, with approximately one-half written off in the first seven years. Previously, they were written off over a three-year period, with one-half written off in the first year. For reporting to state regulatory authorities, the insurance subsidiaries expense these costs as incurred. See Note 2 to Consolidated Financial Statements of National Liberty Life Insurance Company and Subsidiary.

In determining the period over which premium income is expected to be received and the bulk of the acquisition costs are to be amortized, the Company utilizes the Linton B table, one of several standard actuarial tables used in the insurance industry, which, studies have indicated, represents the long-term lapse patterns of a broad range of policy types. The same table is utilized by the Company in setting premium rates charged to its policyholders. The amortization pattern indicated by the Linton B table has been modified by the Company to reflect its actual lapse experience for the first five years (meaningful statistics beyond five years not being available) and to reduce the amortization periods indicated by the Linton B table to twenty years. A comparison between the lapse rates based on the Company's experience and the lapse rates shown by the Linton B table for the first five years is as follows:

[In percent]

	Lapse rate ¹	
	Company's experience	Linton B
Policy year:		
1.....	30	20.0
2.....	20	12.0
3.....	15	10.0
4.....	11	8.8
5.....	8	8.0

¹ The number of policies lapsing in each policy year as a percentage of the policies in force at the beginning of such year.

Premium income expected to be received over the life of any given group of policies is calculated based on expected lapsation as described above. To determine the amount of acquisition costs to be written off to expense for a given group of policies in any given year, the Company multiplies the total acquisition costs (substantially all incurred in the first year) for such group of policies by a fraction, the denominator of which is the sum of all premium income expected to be received over the 20-year period from such group of policies and the numerator of which is the premium income expected to be received in that particular year from such group of policies.

The Company believes that the above approach of matching income and expense is justified because (1) the Linton B table as modified is used in setting premium rates charged to policyholders, and, according to the exposure draft, should be used as the basic element in determining the period over which costs are to be amortized, (2) the modification of the Linton B table for the Company's actual lapse experience is in accordance with the principles contained in the exposure draft, (3) the lapse rates experienced by the Company are trending towards the Linton B table as shown by the above comparison and (4) the modification of the Linton B table results in a more rapid amortization of acquisition costs than would otherwise have resulted had the Linton B table not been modified.

As the Company's experience develops, the Company will compare its lapse rates annually with those utilized in the development of its amortization schedule. In the event that the Company's future experience shows a greater lapse rate than the present rates utilized, the amortization schedule will be modified to reflect current experience and a greater amount of policy acquisition costs will be written off each year. This may have a material adverse effect on the Company's future operating results.

Liability for Policy Reserves.—The liability for policy reserves has been calculated on a net level premium basis, whereas previously (and currently for reporting to state regulatory authorities) the liability for policy reserves had been calculated on a modified preliminary term basis. Adjustments also have been made to reflect the use of different assumed interest earning rates, persistency expectations and morbidity and mortality tables. As a result, policy reserves as of December 31, 1970 were \$37,285,352, as compared to policy reserves on a statutory basis of \$29,033,510.

Deferred Income Taxes.—Deferred income taxes have been provided for after taking the above and other minor adjustments into consideration and were \$18,678,448 as of December 31, 1970.

For additional information, see Notes (a) and (d) to Consolidated Statement of Income of National Liberty Corporation and Subsidiary Companies, Notes 1 and 4 to Consolidated Financial Statements of National Liberty Corporation and Subsidiary Companies and Notes 1, 2, 4 and 5 to Consolidated Financial Statements of National Liberty Life Insurance Company and Subsidiary.

NATIONAL LIBERTY CORPORATION AND SUBSIDIARY COMPANIES CONSOLIDATED STATEMENT OF INCOME (a)

The following consolidated statement of income of National Liberty Corporation and Subsidiary Companies has been examined by Lybrand, Ross Bros. & Montgomery, independent certified public accountants, and their opinion with respect thereto (which is based in part on the report of other certified public accountants) appears elsewhere in this Prospectus. This statement should be read in conjunction with the other consolidated financial statements and related notes of National Liberty Corporation and Subsidiary Companies included elsewhere herein.

	Year ended Dec. 31				
	1966	1967	1968	1969	1970
Revenues: Premium income (g):					
Accident and health.....	\$21,349,097	\$25,117,226	\$25,340,556	\$25,485,967	\$40,856,030
Life.....	7,130,508	7,235,258	8,167,848	8,843,580	5,897,872
Reinsurance assumed.....	2,588	15,756	1,193,005	7,515,693	7,215,295
Total premiums.....	28,482,193	32,368,240	34,701,409	41,845,240	53,951,197
Commission and service income (b).....	4,012	882,299	2,001,774	2,001,774	1,027,343
Investment and other income.....	827,928	1,207,854	1,617,711	2,248,522	2,694,355
Total.....	29,310,121	33,580,106	37,201,419	46,095,536	57,672,895
Costs and expenses:					
Accident and health and other benefits.....	13,703,149	16,036,455	15,526,570	18,377,206	20,388,136
Increase in policy reserves.....	3,355,109	2,050,446	4,117,745	4,622,176	6,902,022
Policy acquisition costs and operating expenses (d).....	12,347,762	15,470,318	18,231,344	24,487,310	39,102,863
Increase in deferred policy acquisition costs (c).....	(5,306,444)	(4,478,809)	(6,670,030)	(11,636,318)	(21,710,128)
Total.....	24,099,576	29,078,410	31,205,629	35,850,374	44,682,893
Income before income taxes, etc.....	5,210,545	4,501,696	5,995,790	10,245,162	12,990,002
Provisions for income taxes:					
Deferred (c).....	1,957,372	1,748,397	2,397,601	3,739,103	3,517,491
State.....	(6,000)	37,000	5,700	25,285	34,230
Total.....	1,951,372	1,785,397	2,403,301	3,764,388	3,551,721
Income before investment gains (losses) and extraordinary gain.....	3,259,173	2,716,299	3,592,489	6,480,774	9,438,281
Investment gains (losses), net of related deferred income taxes (c).....	410	196,839	79,688	(167,047)	(682,948)
Income before extraordinary gain.....	3,259,583	2,913,138	3,672,177	6,313,727	8,755,333
Extraordinary gain on sale of portfolio of insurance, net of related deferred income taxes of \$1,082,958 (e).....					3,353,726
Net income.....	3,259,583	2,913,138	3,672,177	6,313,727	12,109,059
Per share of common stock (f):					
Income before investment gains (losses) and extraordinary gain.....	.41	.34	.43	.74	1.07
Investment gains (losses).....		.02	.01	(.02)	(.08)
Income before extraordinary gain.....	.41	.36	.44	.72	.99
Extraordinary gain.....					.38
Net income.....	.41	.36	.44	.72	1.37

Note: See accompanying notes to consolidated statement of income.

NOTES TO CONSOLIDATED STATEMENT OF INCOME

(a) In 1969, the Company acquired 99% of the outstanding capital stock of National Home Life Assurance Company (National Home) in exchange for 429,812 shares of its common stock. For accounting purposes, the transaction was treated as a pooling of interests and, accordingly, the consolidated financial statements include the results of National Home's operations prior to acquisition. In addition, the operations of the Company's insurance subsidiaries are fully consolidated in the accompanying consolidated statement of income whereas in prior years the adjusted statutory results of National Liberty Life Insurance Company (National Liberty Life), another consolidated subsidiary, and the statutory results of National Home were included on an equity basis. In 1970, the insurance subsidiaries retroactively adopted the principles of reporting operations contained in the exposure draft prepared by the American Institute of Certified Public Accountants (AICPA) as more fully described in Note 1 to Consolidated Financial Statements of National Liberty Corporation and Subsidiary Companies. As a result of the foregoing, net income previously reported has been adjusted as follows:

	1966	1967	1968	1969
Net income as originally reported.....	\$1,840,901	\$1,496,315	\$2,548,978	\$2,919,762
Retroactive adjustment resulting from pooling of interests of National Home.....	(233,519)	(774,202)	(207,483)	-----
Net income as reported in 1969.....	1,607,382	722,113	2,341,495	2,919,762
Retroactive adjustments resulting from adoption of principles contained in AICPA exposure draft:				
Deferred acquisition costs.....	3,795,395	3,695,667	4,367,205	7,381,964
Policy reserves.....	(1,525,121)	(911,233)	(1,656,581)	(451,404)
Deferred income taxes.....	(1,101,372)	(1,252,397)	(2,395,701)	(3,634,565)
Other.....	519,299	658,988	1,015,759	97,970
Net income as reported in accompanying consolidated statement of income.....	3,259,583	2,913,138	3,672,177	6,313,727

See Note (f) below.

(b) In March 1968, DeMoss Associates, Inc., a consolidated subsidiary, entered into a service agreement with the Presidential Life Insurance Agency, Inc. (Presidential) under which DeMoss Associates earned a fee for soliciting insurance policies based on the profitability of the business written. Such fee amounted to \$757,343 for 1968 and \$1,728,271 for 1969. On July 1, 1969, DeMoss Associates, National Liberty Life, National Home, and Presidential entered into agreements pursuant to which the insurance subsidiaries reinsured such business, receiving a reinsurance premium in lieu of DeMoss Associates' receipt of such fee.

(c) For income tax purposes the Company charges policy acquisition costs to income as incurred, while for financial reporting purposes such costs are deferred and amortized over the periods benefited. Deferred income taxes relate principally to the difference in reporting these costs for financial and tax purposes. Deferred income taxes applicable to investment gains (losses) for the five years ended December 31, 1970 amounted to \$380, \$71,000, \$40,000, NONE and (\$111,000), respectively. For further information with respect to income taxes, see Note 6 to Consolidated Financial Statements of National Liberty Corporation and Subsidiary Companies.

(d) Policy acquisition costs capitalized and amortized over future years are the excess first year costs of putting new business on the books, which for direct response business (principally accident and health insurance) is the cost of making the various solicitation efforts and consist primarily of advertising, printing, postage, list rental and the cost of creating and administering solicitations. For the agency business (principally life insurance), this cost is principally the excess first year commission that is paid to nonrelated insurance agents. Operating expenses which are written off as incurred are the cost of maintaining the policies on the books after they have been sold and are primarily made up of the cost of billing and collecting premiums, paying claims and developing necessary reports.

Depreciation is computed under the straight-line method in the consolidated financial statements. Charges to income for the five years ended December 31, 1970 amounted to \$20,842, \$57,100, \$97,626, \$99,139, and \$143,335, respectively. Interest expense charged to income for the five years ended December 31, 1970 amounted to \$34,436, \$40,945, \$29,004, \$6,964, and \$309,771, respectively.

(e) Management is of the opinion that the effect on future income statements as a result of the sale of the portfolio of term mortgage insurance will not be detrimental.

(f) Per share amounts applicable to common stock are based on the average number of shares outstanding during each year adjusted for (1) common stock issued in connection with acquisitions accounted for on a pooling of interests basis, (2) stock distributions including the 4 for 3 distribution in April 1971 (see Note 12 to Consolidated Financial Statements of National Liberty Corporation and Subsidiary Companies) and (3) conversion of the convertible subordinated debentures at date of issue and exercise of outstanding stock options, which are common stock equivalents.

The proceeds from the sale of a portion of the shares offered by this Prospectus will be used to repay the short-term borrowings (\$5,250,000) which were outstanding at December 31, 1970. Had such portion of the offered shares been sold at current prices in lieu of incurring such bank borrowings (and the interest and related income taxes with respect thereto been eliminated from the income statement) pro forma per share of common stock data for 1970 would not have changed significantly.

Had the Company continued (1) to use its former method of accounting for life insurance subsidiaries, (2) to incur policy acquisition costs with respect to direct response solicitation in its agency subsidiary and (3) to amortize such costs over a three-year period in declining annual rates of 50%, 32% and 18%, income before extraordinary gain, extraordinary gain and net income for 1970 would have been \$2,690,066, \$4,413,087 and \$7,103,153, respectively, or \$.31, \$.50 and \$.81 per share, respectively.

(g) First-year and renewal premium income are as follows:

	1966	1967	1968	1969	1970
Accident and health:					
1st year premiums.....	\$9,004,424	\$8,286,155	\$6,288,753	\$9,772,418	\$19,325,110
Renewal premiums.....	12,344,673	16,831,071	20,215,070	22,134,912	27,466,626
Life:					
1st year premiums.....	3,147,615	2,080,349	1,779,195	2,081,909	3,026,305
Renewal premiums.....	3,985,481	5,170,665	6,418,391	7,856,001	4,133,156
Total premiums.....	27,482,193	32,368,240	34,701,409	41,845,240	53,951,197

Premium income in this Note includes reinsurance premium income, substantially all of which is from reinsuring accident and health policies written by DeMoss Associates for unrelated insurers under the arrangements referred to in Note (b) above.

Net income declined in 1967 principally because of losses incurred by National Home on certain group policies which have since been terminated.

The decline in life premium income in 1970 resulted primarily from the sale as of January 1, 1970 by National Home of approximately \$500,000,000 of term mortgage insurance to an unrelated insurance company and from expiration, or termination by National Home in 1969, of eleven group life insurance contracts. National Home has discontinued writing term mortgage insurance. See Note 1 to the table of Life Insurance Premium Income and Notes 4 and 5 to the table of Changes in Life Insurance in Force under "Insurance Operations—Insurance Statistics".

The provision for deferred income taxes in 1970 is lower in relation to net income than in 1969 principally because, beginning September 1, 1970, National Home incurred substantial policy solicitation costs directly instead of paying commissions to DeMoss Associates. This reduced the net income of the latter, which would be subject to a higher effective tax rate than National Home. See Note 8 to Consolidated Financial Statements of National Liberty Life Insurance Company and Subsidiary.

Unaudited Interim Results of Operations.—Set forth below are the unaudited consolidated interim results and per share amounts for National Liberty Corporation and Subsidiary Companies for the six-month periods ended June 30, 1970 and June 30, 1971. In the opinion of the management of National Liberty Corporation, all adjustments (which include only normal recurring accruals) necessary to a fair statement of the information shown below for the respective six-month periods have been included.

6 MONTHS ENDED JUNE 30

	1970 (unaudited)	1971 (unaudited)
Total revenues.....	\$24,432,000	\$40,213,000
Income before investment losses and extraordinary gain.....	3,540,000	5,029,000
Investment losses, net of related deferred income tax benefit of \$111,000 in 1970 and none in 1971.....	(570,000)	(10,000)
Income before extraordinary gain.....	2,970,000	5,019,000
Extraordinary gain on sale of portfolio of insurance, net of related deferred income taxes of \$1,083,000 ¹	3,354,000	
Net income.....	6,324,000	5,019,000
Per share of common stock:		
Income before investment losses and extraordinary gain.....	.40	.57
Investment losses.....	(.07)	
Income before extraordinary gain.....	.33	.57
Extraordinary gain ¹.....	.38	
Net income.....	.71	.57

¹ See note (e) to consolidated statement of income of National Liberty Corp. and subsidiary companies.

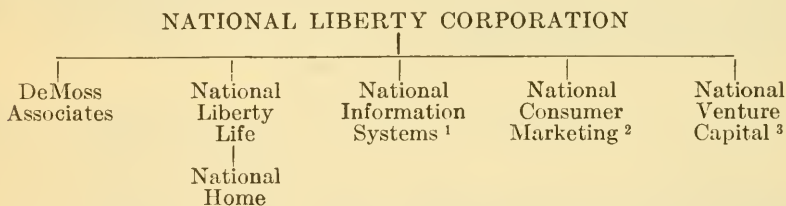
NATIONAL LIBERTY GROUP

National Liberty Group consists of National Liberty Corporation (the "Company"), which is the parent of the Group, National Liberty Life Insurance Company ("National Liberty Life") and its subsidiary, National Home Life Insurance Company ("National Home"), which write accident and health and life insurance, DeMoss Associates, Inc. ("DeMoss Associates"), which solicits insurance business through mass marketing techniques, and several other smaller subsidiaries which are not directly engaged in the solicitation or writing of insurance. The Company, incorporated in Pennsylvania in 1967, acquired all of the outstanding capital stock of DeMoss Associates and National Liberty Life in 1968.

The insurance business of National Liberty Group originated in 1959 when Mr. Arthur DeMoss, as an independent agent, started writing accident and health insurance for abstainers, solicited principally through direct mailings. In 1960, this business was assumed by DeMoss Associates. In 1963, National Liberty Life, then an inactive insurance company owned by Mr. DeMoss, began underwriting some of the new accident and health insurance solicited by DeMoss Associates and acquiring some of the policies which DeMoss Associates had solicited as agent for unrelated insurers. By 1965, National Liberty Life had become the primary insurer for all policies sold by DeMoss Associates. In order to increase the number of states in which it was licensed to write insurance, in 1969 National Liberty Group acquired National Home, which was then licensed to do business in substantially all states except New York. See "Insurance Operations—Regulation".

DeMoss Associates initially sold, primarily through the use of direct mailings, accident and health insurance under the "Gold Star Plan" to people who represented that they abstained from alcoholic beverages. In 1968, DeMoss Associates began soliciting the general public, primarily through the use of newspaper and magazine advertising, as an agent for two unrelated insurance companies. Policies resulting from such solicitation were reinsured by National Liberty Group. The agency agreements with the two independent companies were terminated by DeMoss Associates in 1970, and substantially all of the policies sold pursuant to the agreements have been assumed by National Liberty Group.

The following chart sets forth the principal companies in the National Liberty Group. All subsidiaries shown are wholly-owned except as noted. See "Non-Insurance Subsidiaries"



¹ Owned 75% by the Company, 10% by three of its officers (one of whom is a director of the Company) and 15% by the public.

² Owned 89% by the Company and 11% by its president, who is also a director of the Company.

³ Owned 90% by the Company and 10% by its president, who is a former officer of the Company.

INSURANCE OPERATIONS

MARKETING

The insurance business of National Liberty Group is solicited principally through mass marketing conducted by DeMoss Associates. Marketing expenditures, principally for coupon response advertising, by National Liberty Group for the five years ended December 31, 1970 were:

1966	-----	\$5, 132, 000	1969	-----	\$13, 146, 000
1967	-----	6, 283, 000	1970	-----	24, 102, 000
1968	-----	8, 318, 000			

Expenditures for the first six months of 1971 were \$17,665,000. See "Use of Proceeds" for estimated 1971 and 1972 expenditures and "Certain Factors Affecting Accounting and Profits" for the accounting treatment of these expenditures. The ratio of premium income to marketing expenditures has declined substantially over the past five and one-half years. The Company believes, however, that the effect on net income has been more than offset by the increase in the volume of premium income which has resulted from such marketing expenditures and by improvement in the ratios of losses and costs of maintaining policies on the books to premium income. For a description of such costs see Note (d) to Consolidated Statement of Income of National Liberty Corporation and Subsidiary Companies.

DeMoss Associates presently emphasizes newspaper advertising and direct mail to sell insurance policies and recently has started to test radio and television advertising. A continuing program of testing the results and improving the format of its advertisements is conducted to determine which formats and types of advertising media are most effective for specific market segments and produce the highest return per advertising dollar expended. This testing program involves numerous pilot projects. Each marketing project is monitored by computer, with results evaluated daily, thus providing a basis for close control of expenditures. DeMoss Associates employs approximately 100 persons who are involved in media selection, research, marketing systems and statistics, copy and art work and project management and, in addition, employs four unrelated advertising agencies for certain creative services and for purchasing advertising space.

National Liberty Group maintains contact with existing policyholders through telephone calls and direct mailings to improve policyholder persistency and to promote the sale of additional coverage.

National Home, to a limited extent, also sells insurance (predominantly life insurance) through general agents. In 1970, two non-exclusive agencies began writing insurance for National Home and accounted for the bulk of its premium income of approximately \$1,250,000 from new life insurance written on an agency basis. National Liberty Life has no agents.

TYPES OF INSURANCE WRITTEN

National Home offers a portfolio of individual and group life and accident insurance, and hospitalization and medical insurance, including standard riders, which are underwritten almost entirely on a non-participating basis. National Liberty Life emphasizes the sale of accident and health insurance to abstainers and also offers life insurance to existing holders of its accident and health policies. By direct mail solicitation, it offers convertible term life insurance to college students under its College Life Program.

Under a typical accident and health policy providing disability income coverage during hospitalization, National Liberty Life or National Home agrees to pay the holder at the rate of \$500 a month for the duration of each hospital confinement. Some policies provide for lump sum payments in the event of accidental death or dismemberment. Typical monthly premiums range from \$3.30 to \$8.50, after conversion from a lower introductory monthly premium. Both companies also write medical, surgical and nursing policies providing limited reimbursement for specified surgical and nursing expenses, as well as accident policies providing for payments of specified amounts up to \$1,000 per month, if the insured is hospitalized as the result of an accident.

Substantially all of the accident and health policies written by National Liberty Life since 1968, and by National Home since 1970, are guaranteed renewable by the insured for life. Such coverage may not be cancelled by the insurer, but—except during the price freeze ordered by the President of the United States on August 15, 1971 and any extension thereof—premium rates may be raised uniformly on a state, territorial or nationwide basis, if approved by the appropriate authorities.

Because they emphasize the writing of accident and health and life insurance policies with relatively small benefit payments or face amounts, National Home and National Liberty Life do not usually require medical examinations before issuing such policies. Although each company accepts some substandard life insurance risks at an increased premium, neither emphasizes such coverage.

INSURANCE STATISTICS

The following table sets forth the premium income and income before income taxes of National Liberty Group attributable to direct response solicitations (primarily based on return of coupons from newspaper and direct mail advertising) and to agency solicitations for the five years ended December 31, 1970:

	1966	1967	1968	1969	1970
Premium income:					
Direct response ¹	\$16,333,572	\$22,075,882	\$24,306,111	\$30,253,629	\$47,340,013
Agency.....	12,148,621	10,292,358	10,395,298	11,591,611	6,611,184
Total.....	28,482,193	32,368,240	34,701,409	41,845,240	53,951,197
Income before income taxes: ²					
Direct response ³	4,527,995	5,036,993	5,572,583	9,308,498	12,122,430
Agency.....	682,550	(535,297)	423,297	936,664	867,572
Total.....	5,210,545	4,501,696	5,995,790	10,245,162	12,990,002

¹ Includes reinsurance premium income of (\$205,872) in 1966, none of 1967, \$1,163,267 in 1968, \$5,421,363 in 1969 and \$5,935,706 in 1970.

² Before income taxes, investment gains and losses and extraordinary gain.

³ Includes pretax income of DeMoss Associates resulting from its solicitation of policies for unrelated insurers and a minor amount of pretax income of the noninsurance subsidiaries.

Geographical Distribution.—Premium income of National Liberty Group in 1970 was received from all 50 states. Ten states produced approximately 60% of premium income in 1970, and the most important of these, Pennsylvania, produced approximately 9%. Premium income from the 17 states producing in excess of \$1,000,000 in 1970 was as follows:

Pennsylvania	\$4,841,398	Indiana	\$1,897,664
California	4,175,092	Texas	1,431,935
Ohio	3,814,728	Virginia	1,281,515
Illinois	3,718,459	North Carolina.....	1,092,758
New York.....	3,414,068	Washington	1,056,953
Florida	3,229,922	Iowa	1,050,384
Missouri	2,661,712	Wisconsin	1,042,013
Michigan	2,296,670	Minnesota	1,028,246
New Jersey.....	2,200,931		

Accident and Health Insurance.—National Liberty Life and National Home have in force approximately 800,000 accident and health policies insuring approximately 1,100,000 persons. As of December 31, 1970, the average age of insureds at time of issue of their policies was 52. Approximately 44% of premium income of National Home and National Liberty Life in 1970 was from policies written for abstainers.

The following table sets forth certain statistical information on a statutory basis (see Note 1 below) pertaining to the accident and health insurance operations of National Home and National Liberty Life for the five years ended December 31, 1970:

	1966	1967	1968	1969	1970
Net premiums collected (statutory basis):					
Direct response.....	\$18,352,217	\$21,003,130	\$23,012,011	\$28,685,747	\$45,079,362
Agency.....	6,071,485	4,834,217	4,045,009	3,824,568	2,393,654
Combined.....	24,423,702	25,837,347	27,057,020	32,510,315	47,473,016
Net premiums earned:					
Direct response.....	15,331,679	20,558,906	22,474,087	28,026,907	44,465,671
Agency.....	6,017,418	4,558,320	4,029,736	3,880,423	2,326,065
Combined.....	21,349,097	25,117,226	26,503,823	31,907,330	46,791,736
Losses incurred (including increase in accident and health reserves):					
Direct response.....	7,495,752	9,762,163	11,010,091	11,281,950	20,366,248
Agency.....	3,893,783	2,489,190	2,582,618	2,434,433	1,505,531
Combined.....	11,389,535	12,251,353	13,592,709	15,716,383	21,871,779
Underwriting expenses incurred:					
Direct response ¹	7,933,346	9,484,750	9,013,098	12,509,098	28,032,172
Agency.....	2,380,265	1,801,480	1,664,601	1,548,154	1,042,442
Combined.....	10,313,611	11,286,230	10,677,699	14,057,252	29,074,614
Ratio of losses incurred to net premiums earned (percent):					
Direct response.....	48.9	47.5	49.0	47.4	45.8
Agency.....	64.7	54.6	64.1	62.7	64.7
Combined.....	53.4	48.8	51.3	49.2	46.7
Ratio of underwriting expenses incurred to net premiums collected (percent):					
Direct response ¹	43.2	45.2	39.2	43.6	62.2
Agency.....	39.2	37.3	41.2	40.5	43.6
Combined.....	42.2	43.7	39.5	43.2	61.3
Underwriting profit (loss) ratio (percent): ²					
Direct response ¹	7.9	7.3	11.8	9.0	(8.0)
Agency.....	(3.9)	8.1	(5.3)	(3.2)	(8.3)
Combined ¹	4.4	7.5	9.2	7.6	(8.0)

¹ Prior to 1970, all solicitation costs relating to direct response business were incurred by DeMoss Associates, which received as compensation therefor 1st-year and renewal commissions from National Liberty Life or National Home. Had the insurance subsidiaries incurred solicitation costs directly (and not paid commissions to DeMoss Associates), direct response underwriting expenses incurred (and the ratio of direct response underwriting expenses incurred to net premiums collected) would have been significantly higher and the direct response underwriting profit (loss) ratio would have been significantly lower and in some years would have been negative. In 1970, \$8,621,576 of solicitation costs were incurred by National Home, reflecting a decision to have National Home incur a portion of the solicitation costs. Such costs are reflected in direct response underwriting expenses for that year. Had the prior practice been continued, direct response underwriting expenses incurred would have been \$7,284,202 lower, which would have changed the ratio of direct response underwriting expenses incurred to net premiums collected to 46.0 percent, the direct response underwriting profit ratio to 8.2 percent and the combined underwriting profit ratio to 7.4 percent.

² The difference between 100 percent and the sum of the footnote ¹ ratio of losses incurred to net premiums earned and footnote ² ratio of underwriting expenses incurred to net premiums collected.

Life Insurance Premium Income.—The following table sets forth the life insurance premium income of National Home and National Liberty Life for the five years ended December 31, 1970:

	1966	1967	1968	1969	1970
Ordinary life:					
Direct Response.....	\$1,001,893	\$1,516,976	\$1,832,024	\$2,179,470	\$2,849,237
Agency.....	3,860,202	3,695,560	4,231,796	4,784,693	3,003,871
Group life.....	2,271,001	2,038,478	2,133,766	2,973,747	1,300,353
Total.....	7,133,096	7,251,014	8,197,586	9,937,910	17,159,461

¹ See Notes 4 and 5 to the following table. First-year premium income from ordinary life in 1970 was \$2,575,936 as compared to \$1,553,100 in 1969.

Changes in Life Insurance in Force.—The following table sets forth the changes in life insurance in force for the five years ended December 31, 1970:

	1966	1967	1968	1969	1970
In force at Jan. 1 ¹	\$384, 615, 654	\$654, 781, 685	\$941, 837, 497	\$1, 093, 109, 492	\$1, 323, 445, 012
Life insurance written:					
Whole life.....	22, 754, 591	13, 438, 793	36, 241, 419	67, 905, 639	112, 386, 081
Group life.....	87, 811, 449	2, 295, 200	22, 979, 174	² 243, 731, 013	38, 487, 723
Term.....	205, 358, 114	³ 391, 436, 004	252, 789, 267	224, 838, 857	⁴ 100, 374, 150
Total.....	315, 924, 154	407, 169, 997	312, 009, 860	536, 475, 509	251, 247, 954
Terminations:					
Death.....	2, 600, 887	3, 576, 862	3, 655, 779	4, 881, 055	1, 994, 029
Expiry.....	7, 232, 392	18, 412, 664	11, 658, 945	⁵ 126, 986, 622	847, 364
Surrender.....	1, 225, 776	1, 174, 200	782, 954	1, 410, 981	2, 407, 035
Lapse.....	21, 981, 090	70, 229, 870	139, 005, 761	161, 414, 772	161, 304, 200
Decrease.....	12, 717, 978	26, 720, 589	5, 634, 426	11, 446, 559	⁴ 595, 242, 311
Total.....	45, 758, 123	120, 114, 185	160, 737, 865	306, 139, 989	761, 794, 939
In force at Dec. 31: ¹					
Whole life.....	53, 752, 094	59, 152, 854	72, 998, 251	119, 204, 190	191, 750, 199
Group life.....	245, 364, 932	228, 016, 701	237, 993, 395	² 352, 936, 693	² 206, 950, 245
Term.....	355, 664, 659	654, 667, 942	782, 117, 846	851, 304, 129	⁴ 414, 197, 583
Total.....	654, 781, 685	941, 837, 497	1, 093, 109, 492	1, 323, 445, 012	812, 898, 027
Lapse ratio (percent) ⁶	21	21	19	18	15

¹ Reinsurance ceded has not been deducted; reinsurance assumed has been included. Insurance in force at Dec. 31 of each of the years 1965 through 1970 which had been ceded was as follows: 1965—\$12,455,614; 1966—\$15,622,922; 1967—\$195,309,818; 1968—\$226,032,541; 1969—\$222,983,049; 1970—\$62,873,039. See "Reinsurance".

² Group life in force includes insurance under Federal Employees Group Life Insurance (FEGLI), Service Employees Group Life Insurance (SEGLI) and Pennsylvania Employees Group Life Insurance (PEGLI) of \$188,956,735 in 1969 (the 1st year in which National Liberty Group participated in these programs) and \$172,736,949 in 1970.

³ In 1967, National Liberty Life made a special offer to college students of a term policy converting automatically to whole life insurance at age 25.

⁴ As of Jan. 1, 1970, National Home sold approximately \$500,000,000 of term mortgage insurance to an unrelated insurance company and discontinued this line of business. Premium income from this business in 1969 was approximately \$3,674,000. This business was sold to obtain a higher return on invested capital. See Note (e) to Consolidated Statement of Income of National Liberty Corp. and Subsidiary Companies.

⁵ In 1969, 11 National Home group policies expired or were terminated.

⁶ Lapse ratios relate only to ordinary business (whole life and term) and are determined by dividing the total number of policies surrendered and lapsed by the mean number of policies in force. Since data for group contracts do not reflect surrender or lapse of individual policies, lapse ratios for group contracts are normally not meaningful.

Investments and Investment Results.—The investment committee, which is appointed by and responsible to the board of directors of the Company, meets monthly to formulate investment policies and guidelines (including specific limitations with respect to classes of investments) and to review the activities of the investment department. For membership of the investment committee, see "Management—Directors and Executive Officers". To ensure appropriate diversification, no more than two per cent of total investment assets are invested in the securities of any one issuer, except U.S. government securities. Additional restrictions under state insurance laws are also applicable to the insurance subsidiaries. The investment department executes transactions in marketable securities pursuant to such guidelines with the prior approval of any two members of the investment committee. These investments are subsequently reviewed by the full committee. Transactions in non-liquid investments must be made with prior approval of two-thirds of the investment committee.

The investment results of National Home and National Liberty Life during each of the last five years, on a statutory basis, were as follows:

Year	Average		Net investment income ²	Rate of return		Net realized gains (losses) on investments ³	Net unrealized gains (losses) on investments ⁴
	Cash	Investments ¹		Cash and investments (percent)	Investments (percent)		
1966.....	\$935,556	\$15,747,473	\$752,553	4.37	4.78	\$59,302	(\$58,513)
1967.....	1,035,778	19,685,821	954,836	4.38	4.85	139,199	128,641
1968.....	1,381,419	23,841,807	1,217,325	4.64	5.11	110,403	9,285
1969.....	2,568,416	29,375,736	1,735,554	5.24	5.91	136,610	(303,657)
1970.....	3,763,357	36,500,397	2,313,836	5.87	6.33	(474,734)	(319,215)

¹ Does not include real estate investments which consist primarily of investment in home office buildings and land. See Note 3 to Consolidated Financial Statements of National Liberty Life Insurance Co. and subsidiary.

² Net investment income (not including real estate income) after deduction of investment expenses and before net realized gains and losses and Federal income taxes. Bond interest includes amortization of discounts and premiums.

³ Before Federal income taxes

⁴ Since bonds are carried principally at amortized cost and preferred stocks principally at cost, net unrealized gains (losses) represent principally changes in market values of common stocks.

REINSURANCE

Both National Home and National Liberty Life follow the customary practice of reinsuring portions of their insurance risks with other carriers. Currently, both reinsure with unrelated companies all risks which exceed \$100,000.

The following table sets forth the reinsurance activities of National Home and National Liberty Life for the past five years.

REINSURANCE CEDED

Year	Life insurance			Accident and health insurance	
	In force	Earned premiums paid	Reinsurance benefits received	Earned premiums paid	Reinsurance benefits received
1966.....	\$15,622,922	\$126,823	\$62,262	\$205,872	\$624,017
1967.....	195,309,818	862,183	494,897	-----	-----
1968.....	226,032,541	862,115	395,324	-----	-----
1969.....	222,983,049	1,031,771	596,203	-----	-----
1970.....	62,873,039	469,413	119,643	-----	-----

¹ Ceded by National Home in order to meet minimum statutory reserve requirements.

REINSURANCE ASSUMED

Year	Life insurance			Annuities		Accident and health insurance ¹	
	In force	Earned premiums received	Reinsurance benefits paid	Earned premiums received	Reinsurance benefits paid	Earned premiums received	Reinsurance benefits paid
1966.....	(²)	\$2,588	-----	-----	-----	-----	-----
1967.....	\$5,426,870	15,756	\$4,497	-----	-----	-----	-----
1968.....	9,847,852	29,738	-----	-----	-----	\$1,163,267	\$348,451
1969.....	55,354,479	1,094,330	-----	-----	-----	6,421,363	1,468,341
1970.....	15,020,057	930,782	10,084	\$348,807	\$41,228	5,935,706	1,954,468

¹ Represents principally insurance written by DeMoss Associates through direct response solicitations for unrelated insurers. These arrangements were terminated in 1970 and these policies were assumed by National Home.

² Information not available.

REGULATION

The insurance laws of the various states confer upon supervisory authorities broad administrative powers relating to the granting and revoking of licenses to transact business, the approval of premium rates, the regulating of trade practices, the licensing of agents, approval of the form and content of policies and advertising, the depositing of securities for the benefit of policyholders, investments, the form and content of financial statements and the maintenance of specified reserves and capital for the protection of policyholders. In general, insurance laws and regulations are designed principally to protect policyholders rather than shareholders. National Home is subject to regulation by the Division of Insurance, Department of Business and Administration, of the State of Missouri, and National Liberty Life is subject to regulation by the Pennsylvania Insurance Department. Both are subject to certain regulation and supervision by comparable authorities in other jurisdictions. The last completed examination of the books and records of National Home by Missouri, and of National Liberty Life by Pennsylvania, was as of December 31, 1968.

National Liberty Group is presently licensed to transact its insurance business in 47 states and Puerto Rico. A newly formed subsidiary was recently licensed to transact accident and health insurance business in New York. In 1969 National Home's licenses in Connecticut and the District of Columbia, and in 1970 its license in New Hampshire, were not renewed as a result of a statutory reserve impairment which occurred prior to acquisition of National Home by the Company. National Liberty Group is actively seeking admission in each of those jurisdictions as well as in Hawaii. No assurance can be given that any such licenses will be granted.

The statutory reserve impairment referred to above was remedied by a contribution by the Company to National Home's capital of \$1,450,000 in 1969. National Home incurred in 1970, and is expected to continue to incur, a statutory loss because of substantial marketing expenditures. National Liberty Life made a contribution of \$5,194,000 to the capital of National Home in 1970 to provide for such expenditures, and intends to make additional capital contributions to National Home on a quarterly basis for such purposes. Contributions aggregating \$5,015,038 were made in the first half of 1971.

Various states have also enacted legislation which requires registration and periodic reporting by insurance companies licensed to transact business within their respective jurisdictions and which are controlled by other corporations. National Liberty Life and National Home are subject to such legislation and are registered as controlled insurers in those jurisdictions in which such registration is required. Such legislation typically requires periodic disclosure concerning the corporation which controls the registered insurers, or ultimate holding company, and all subsidiaries of the ultimate holding company and prior approval of intercorporate transfer of assets (including in some instances payment of dividends by the insurance subsidiary) within the holding company system.

National Liberty Group relies to a large extent on coupon response advertising, the form and content of which is subject to regulation by various governmental agencies, including the Federal Trade Commission.

RESERVES

In the statements furnished to state regulatory authorities, and in accordance with insurance laws and regulations, National Home and National Liberty Life carry as liabilities reserves consisting of unearned premiums and reserves for amounts not paid on reported claims and for claims incurred but not yet reported. In addition, both companies maintain reserves for the guaranteed renewable provisions of their accident and health policies.

Both companies also carry, as liabilities, reserves to meet their obligations on outstanding life policies. These reserves are amounts which, with additions from premiums to be received and with interest on such reserves compounded annually at certain assumed rates, are calculated to be sufficient to meet their policy obligations upon maturity. Life insurance reserves are stated after deduction of reserves on any reinsurance ceded to other companies.

The standards for computing reserves are described in Note 4 to Consolidated Financial Statements of National Liberty Life Insurance Company and subsidiary.

COMPETITION

The insurance industry is highly competitive. The insurance subsidiaries of National Liberty Group compete with over 1700 stock and mutual life insurance companies, many of which sell accident and health insurance, and with more than 800 accident and health insurance companies. The insurance subsidiaries also compete with private, voluntary and cooperative plans for meeting hospital, medical and surgical expenses including Blue Cross and Blue Shield. Many of these competitors have been in business for a longer time, have greater financial resources and offer a more diversified line of coverage than the insurance subsidiaries.

National Liberty Group also competes with the government-sponsored "Medicare" program, which provides hospital and medical benefits to persons entitled to Social Security benefits and others 65 years of age and over. The federal government and the states also sponsor "Medicaid" programs for the benefit of lower income individuals and families. Future expansion of the Medicare or Medicaid programs or the institution of additional government health programs could adversely affect the future volume of accident and health insurance written by National Liberty Group.

RECENT EVENT

On April 20, 1971 National Home entered into a contract to reinsure, with right to assume, the accident and health policies of Executive Fund Insurance Company of Omaha, Nebraska. This reinsurance contract was effective as of March 25, 1971, and has been approved by the Nebraska Department of Insurance and by a commission composed of the Superintendent of Insurance of Missouri and the Directors of Insurance of Nebraska and Ohio. This transaction involves the payment of no consideration to Executive Fund Insurance Company by National Home other than the assumption of the policies. Approximately 125,000 policies are involved, substantially all of which were solicited through mass marketing techniques and all of which are cancellable by the insurer on a restricted basis.

At the time of the effective date of the transaction, premium income from this business was being received at an annualized rate of approximately \$10,000,000. Because of the date of assumption, and because of normal policy lapses, the premium income to be received by National Home from this business during 1971 will be substantially less than that amount.

The Company expects to realize no material profit or loss in 1971 as a result of this transaction, although no assurance of the latter can be given. The Company considers that the principal asset acquired in the transaction is the list of policyholders, which may be used by the Company for the offering of supplemental coverage.

NON-INSURANCE SUBSIDIARIES

NATIONAL INFORMATION SYSTEMS CORPORATIONS

National Information System's Corporation ("NIS"), formed in 1969, is an information systems management company. NIS provides information services to National Liberty Group, as well as to non-affiliated businesses in the insurance and other industries. Total revenues in 1969 and 1970 were \$1,625,353 and \$3,888,523, respectively, of which 96% and 78% were from National Liberty Group. Net income of NIS was \$74,758 and \$178,103 in 1970. On December 31, 1970, consolidated total assets were \$2,529,903 and consolidated capital and surplus were \$1,854,808. In January 1969, National Liberty Life sold its data processing equipment and related software to NIS for an amount equal to the carrying value of such equipment. Subsequently, NIS entered into an agreement with National Liberty Life to provide data processing services. Approximately 75% of NIS' common stock is owned by the Company, 10% by certain officers of NIS

(including Mr. Carl Sempier, who is president of NIS and a director of the Company) and 15% by the public. See "Management—Certain Transactions".

NIS currently leases from IBM two System 360 computers, a Model 40 and a Model 50, as well as certain related components and equipment. The aggregate monthly rental for all such leased equipment is approximately \$94,000. NIS has on order for delivery in October 1971 a new IBM System 370 Model 155 computer; the total rental will then be approximately \$110,000 per month.

NATIONAL CONSUMER MARKETING CORPORATION

National Consumer Marketing Corporation ("NCM"), formed in 1970, provides marketing, advertising, media and publishing services for National Liberty Group, as well as for non-affiliated companies. Total revenues of NCM and its subsidiaries in 1970 were \$1,447,969, of which 87.8% was from National Liberty Group. Net income of NCM in 1970 was \$90,798. On December 31, 1970, consolidated total assets were \$470,187 and consolidated capital and surplus were \$180,798. Approximately 89% of NCM's common stock is owned by the Company and the remainder is owned by Mr. Charles M. Cavanagh, the president of NCM and a director of the Company. See "Management—Certain Transactions".

NATIONAL VENTURE CAPITAL CORPORATION

National Venture Capital Corporation ("NVC") was formed in 1970 to participate in venture capital investments not statutorily qualified for the Company's insurance subsidiaries. To date NVC, which began with investment funds of \$500,000, has made venture capital investments of only about \$65,000. The balance is held in short term securities. 90% of the common stock of NVC is owned by the Company and 10% by Mr. John G. Sterious, the president of NVC and a former vice president of the Company. See "Management—Certain Transactions".

In view of the Company's need for marketing funds and the lack of satisfactory investment opportunities, the Company intends to liquidate this subsidiary in the near future.

PROPERTY

The headquarters and principal offices of National Liberty Group are located in a four-story building completed in January 1971 and owned by National Liberty Life. This building contains approximately 135,000 square feet of floor space and is located on a 93 acre tract in Chester County, Pennsylvania. Approximately 20 acres are presently in use. National Liberty Life intends to mortgage this building as security for a loan of approximately \$4,500,000, the proceeds of which will be used to purchase securities statutorily qualified for life insurance companies.

On July 1, 1971, National Home transferred substantially all its operations to the headquarters of National Liberty Group. It intends to sell or rent its former home office building, which is a five-story structure in St. Louis, Missouri containing approximately 30,525 square feet of floor space, of which approximately 6,528 square feet are leased to others.

PERSONNEL

National Liberty Group has approximately 800 employees. Group life insurance and hospital and surgical benefit plans, a Profit-Sharing Plan and a Stock Purchase Plan are provided for eligible employees, for which National Liberty Group bears some or all of the cost depending on the type of plan and the length of employment. See "Management". A non-contributory pension plan for National Home employees has been terminated subject to regulatory approval. Thereafter these employees will participate in the Group's Profit-Sharing Plan. The total cost of all these plans to National Liberty Group in 1970 was \$275,358.

MANAGEMENT

DIRECTORS AND EXECUTIVE OFFICERS

The directors of the Company and their principal occupations are:

<i>Name</i>	<i>Principal occupations</i>
William W. Scranton (1) (2) -----	Chairman of the Board; private investments; former Governor of Pennsylvania.
Arthur DeMoss (1) (2) -	President of the Company.
Richard Wolke (1) (2) --	Senior Vice President of the Company.
Frank Carlson-----	Former United States Senator from the State of Kansas.
Charles M. Cavanagh (1) -----	President, NCM.
Joseph F. Decosimo (2) -	Partner, Hazlett, Lewis & Beiter, certified public accountants.
Wallace A. Erickson----	President, Wallace A. Erickson & Company, plastics and vinyl products.
Emerson Foote-----	Chairman of the Board, DeMoss Associates.
John W. Keller (1)-----	President, National Liberty Life.
David H. Jaquith-----	Chairman of the Board, Vega Industries, Inc., manufacturer of construction specialty products.
William A. Patty (1)----	Vice President and Counsel of the Company.
Harvey Scharfman-----	President, Cotton Club Frocks, Inc., clothing and apparel manufacturer.
F. Carl Schumacher----	President, Hickey-Mitchell Company, insurance agency; Chairman of the Board, Mercantile Insurance Agency.
William H. Shipley (1) -	President, DeMoss Associates.
Carl G. Sempier (1)----	President, NIS.
Robert E. Slater (2)----	President, Investors Overseas Services, Ltd., investments.
T. Robert Wilcox (1) (2) -----	President, National Home.
W. Marvin Watson-----	President, Occidental International Corporation, petroleum products; former Postmaster General of the United States.
G. Tom Willey-----	Management Consultant.

The other executive officers of the Company are:

<i>Name</i>	<i>Position</i>
W. Benjamin Weaver (2) -----	Vice President and Treasurer.
James D. Elliott-----	Vice President—Corporate Services.
Daniel W. B. Flint-----	Secretary and Associate Counsel.
Andrew L. Heiskell (2) -	Vice President—Investments.

(1) Member of the executive committee.

(2) Member of the investment committee.

Except for Messrs. DeMoss and Weaver, none of the Company's executive officers or directors who are also executive officers of subsidiaries has been employed by National Liberty Group for more than five years. The principal occupations of such officers and directors between the end of 1965 and their employment by National Liberty Group were as follows: Mr. Woike—President, Amalgamated Labor Life Insurance Company to 1966; Mr. Cavanagh—Vice President, Christian Herald Association, publishers, to 1967; Director of Marketing Services, Crowell-Collier & MacMillan, Inc. from 1967 to 1969; Mr.

Keller—Vice President, Operations, Government Employees Insurance Company to 1970; Mr. Patty—private law practice to 1969; Mr. Sempier—International Business Machines Corporation to 1966; Assistant Vice President, Penn Central Company from 1966 to 1969; Mr. Shipley—Manager of Institutional Sales, Procter & Gamble Company to 1968; Vice President, Estee Candy Company from 1968 to 1970; Chairman, CSI Computer Systems, Inc. to May 1970; Mr. Wilcox—Vice President, Hartford Life Insurance Company to 1968; Mr. Elliott—Division Personnel Manager, Alistate Insurance Company to 1969; Mr. Flint—private law practice to 1967; Mr. Heiskell—White, Weld & Co. to 1969.

REMUNERATION

The following table sets forth information as to each director, and each of the three highest paid officers, of the Company whose aggregate direct remuneration paid by National Liberty Group in 1970 exceeded \$30,000, and as to all persons, as a group, who were directors or officers of the Company at any time during 1970:

Name and capacities in which remuneration was received	Salary ¹	Contribution by company to	
		Profit-sharing plan	Stock purchase plan
Arthur DeMoss, president of the company.....	\$48,000	-----	-----
Charles M. Cavanagh, president of NCM.....	32,668	-----	-----
William A. Patty, vice president and counsel of the company.....	35,000	\$1,267	-----
Carl G. Sempier, president of NIS.....	35,000	2,527	-----
T. Robert Wilcox, president of National Home.....	35,000	-----	-----
Richard Woike, senior vice president of the company.....	37,000	2,690	\$2,400
25 directors and officers as a group.....	472,805	12,613	2,400

¹ Payments to Messrs. Patty and Sempier are pursuant to employment contracts providing for at least the remuneration shown for terms of 2 and 3 years, respectively. In addition, Mr. John W. Keller, a director of the company and president of National Liberty Life, receives payments under an employment contract at the rate of at least \$35,000 annually until 1975.

STOCK OPTIONS

As of May 31, 1971, options to purchase 52,867 shares of Common Stock were outstanding, and options to purchase an additional 97,133 were available for grant, under the Company's Stock Option Plan. The options granted under the Plan are intended to be qualified stock options as defined in the Internal Revenue Code. Options are granted to officers and key employees of National Liberty Group at the current market price on the date of grant. Certain directors and officers of the Company who are not eligible to receive options determine the price, the terms of the options and the persons to receive the options.

Under the Stock Option Plan, options may be granted until ten years after adoption of the Plan; they expire no later than five years from the date of grant and are exercisable in various amounts annually. In some cases, options are exercisable only if the Company's earnings per share attain a specified growth rate. Options are generally non-transferable, and no individual may be granted options covering 20% or more of the total number of shares subject to the Plan. Options which are not exercised are available for further grant.

As of May 31, 1971, the following options had been granted:

Name	Number of shares subject to option	Weighted average option price	Expiration dates
Mr. T. Robert Wilcox.....	6,000	\$10.88	1973
Mr. Carl G. Sempier.....	2,000	16.25	1974
Mr. Charles M. Cavanagh.....	1,667	22.80	1975
All officers, directors and key management persons as a group.....	52,867	16.85	1973-1976

Note: See Note 8 to consolidated financial statements of National Liberty Corporation and subsidiary companies.

NIS also has a qualified stock option plan under which options to purchase 100,549 shares of NIS Common Stock were outstanding and options to purchase an additional 55,880 shares were available for grant as of May 31, 1971. Options thereunder may be granted by NIS' board of directors to key employees of NIS at an option price equal to the fair market value of the stock at the date of grant. No employee may be granted options exceeding 20% of the total number of shares subject to the plan. Options will be immediately exercisable as to 20% of the optioned shares and will be exercisable cumulatively as to an additional 20% of such shares on each anniversary of the date of grant. All such options must be exercised prior to the fifth anniversary of the date of grant, and generally are not transferable.

The following table sets forth information, as of May 31, 1971, as to options granted by NIS pursuant to its Stock Option Plan:

Year of grant	Number of shares of NIS subject option	Option prices	Expiration dates
1969-----	45,700	\$3.00 to \$8.25	1974
1970-----	44,349	\$3.25 to \$10.50	1975
1971-----	10,500	\$3.00 to \$4.00	1976

STOCK PURCHASE PLAN

Under the Company's Stock Purchase Plan, eligible officers and employees of National Liberty Group may elect to have a percentage of their compensation (not to exceed 8%) withheld through payroll deductions. Depending upon the net earnings of the Company, National Liberty Group matches a minimum of 25% and a maximum of 100% of each participant's contributions. All funds in the Stock Purchase Plan are used by the Plan's corporate trustee to buy shares of Common Stock in the open market. During 1970, a total of \$69,561 was deducted from the salaries of employees participating in the Stock Purchase Plan and \$66,891 was contributed by National Liberty Group, including \$2,400 on behalf of an officer of the Company.

PROFIT-SHARING PLAN

The Company has adopted a Profit-Sharing Plan under which the Company and its qualified subsidiaries contribute each year such amount, if any, of their consolidated net income before taxes as the Company's board of directors may decide, but not in excess of 15% of the aggregate compensation of Plan members. The amount of this contribution is allocated to eligible officers and employees pursuant to a formula based upon the amount of each participating employee's compensation and his term of employment. The Plan is designed to meet the requirements of a "qualified plan" under the Internal Revenue Code. Eligible employees may contribute up to 10% of their compensation through payroll deductions. All funds in the Profit-Sharing Plan contributed by participants are invested at the discretion of the Plan's corporate trustee (except that no such funds may be invested in Common Stock of the Company), and all funds in the Plan contributed by National Liberty Group are invested by such trustee primarily in shares of Common Stock. During 1970, \$131,249 was contributed by National Liberty Group, including \$12,613 on behalf of all officers and directors of the Company.

CERTAIN TRANSACTIONS

In 1968 Mr. Arthur DeMoss entered into an agreement with National Liberty Life extending until March 1972 under which he agreed to reimburse National Liberty Life for any back premium taxes due for years prior to 1969 in excess of the amounts accrued for such taxes. This agreement was made to limit the exposure of the Company for back premium taxes; however, the amount accrued for such taxes has been substantially in excess of claims against National Liberty Life, and no payments under the agreement have been made.

In 1968, G. H. Walker & Co., Inc., with which Raun J. Rasmussen, a former director of the Company, was affiliated, received underwriting discounts and commissions of \$213,425 in connection with a public offering of the Company's Common Stock.

In 1969, NIS entered into a five-year employment contract with Mr. Sempier, its president, under which he received a salary of \$35,000 in the first year and will receive not less than \$35,000 annually thereafter. In addition, he has received an option to purchase 2,000 shares of Common Stock under the Company's Stock Option Plan. At its formation, NIS sold 100,000 shares of its Common Stock to Mr. Sempier, 245,000 shares to three other of its officers and 2,400,000 shares to the Company for 15 cents per share. In connection with Mr. Sempier's purchase of these shares, NIS loaned him \$12,000, which has been repaid.

In 1970, Mr. John G. Sterious, president of NVC and a former vice president of the Company, purchased 10% of the outstanding common stock of NVC for \$50,000, and the Company purchased the balance for \$450,000. In connection with Mr. Sterious' purchase of these shares, NVC loaned him \$25,000 which has been repaid.

In 1970, Mr. Charles M. Cavanagh, a director of the Company and president of NCM, purchased approximately 11% of its outstanding common stock for \$10,000 in cash and the Company purchased the balance for \$80,000. In 1970, the Company loaned Mr. Cavanagh \$35,000 for approximately one month.

The purchases referred to in the three preceding paragraphs are pursuant to a Company practice of permitting key executives of newly created subsidiaries to acquire a minority interest in such subsidiaries. In each case the executive is required to pay the same per share purchase price for the stock he acquires as is paid by the Company. Messrs. Cavanagh and Sterious did not purchase their stock pursuant to written agreements, but did execute letters of transmittal and cross-receipt.

The Company has had a line of credit with the Northeastern Pennsylvania Bank and Trust Company, Scranton, Pennsylvania since December 1969. Mr. William Scranton, Chairman of the Company, is a director of that bank. This line initially was for \$1,500,000, which was increased to \$2,500,000 on May 4, 1970. The Company first used this line of credit on April 15, 1970 when \$750,000 was borrowed. The maximum loan balance outstanding under the line has been \$2,500,000. The Company has paid a total of \$168,661 in interest to the bank through May 31, 1971.

Mr. Emerson Foote, a director of the Company, presently receives an annual salary of \$25,000 as chairman of the board of DeMoss Associates. In 1969 and 1970, he received \$7,499 and \$20,004, respectively, in consulting fees from that company.

As the result of an exchange offer in April 1969, the terms of which were identical to those offered all of the stockholders of National Home, Mr. F. Carl Schumacher (who is now but was not then a director of the Company), his wife and companies not affiliated with National Liberty Group, with which Mr. Schumacher is associated, received 75,712 shares of the Company's Common Stock (as adjusted for stock splits).

During 1968 and 1969, National Liberty Life paid to Mr. William A. Patty, vice president, counsel and a director of the Company, an aggregate of \$57,500 of which \$20,000 was accrued in 1967, \$32,000 in 1968, and \$5,500 in 1969. Mr. Patty became a director in March 1968, counsel in 1969 and a vice president in 1970.

The Company purchased 20,000 shares of the common stock of Utilities Leasing Corporation ("Utilities Leasing") on September 20, 1968. The proposal to make the investment was made to Mr. John G. Sterious by representatives of Utilities Leasing and called for the purchase of 80,000 shares of Utilities Leasing at \$5 per share. Since the Company was not willing to invest \$400,000, Mr. Sterious contacted several private investors: Sterling Investors ("Sterling"), three of whose six partners were then directors or officers of the Company (Messrs. Arthur DeMoss, Joseph F. Decosimo and John Sterious), FMR Development Corporation ("FMR"), a non-affiliated concern, Liberty Investors (an investment partnership which ultimately did not participate) and Dr. Harry Constantine, the brother-in-law of Mr. Sterious.

On September 20, 1968, at the time of the Company's purchase of 20,000 shares of the common stock of Utilities Leasing for \$100,000, 60,000 shares of common stock of Utilities Leasing were also purchased in the Company's name for \$300,000 on behalf of the following: (a) 10,000 shares for Dr. Constantine; (b) 20,000 shares for FMR; and (c) 30,000 shares for Sterling. Prior to paying Utilities Leasing for the 60,000 shares, the Company had received most of the \$300,000 paid on behalf of these three persons and was promptly reimbursed for the balance.

The September 20, 1968 agreement with Utilities Leasing stated that the certificates representing the Utilities Leasing shares would bear a restrictive legend, and the certificates representing the 20,000 shares purchased by the Company bore such a legend. In October 1969, the Company sold 5,000 of the shares of Utilities Leasing owned by the Company to C.E.L. Inc., a corporation unaffiliated with National Liberty Group, for \$50,000. C.E.L. Inc. purchased the shares for investment only and not with a view to distribution or resale, and the certificates transferred to C.E.L. Inc. bore a restrictive legend to this effect. The Company still owns 15,000 shares of Utilities Leasing common stock, representing the balance of its September 1968 investment. See "Litigation".

On September 23, 1968, at the time of the purchase of 400 shares of the common stock of Total Energy Leasing Company ("Total Energy") by the Company for DeMoss Associates, Inc., 2,100 shares of the common stock of Total Energy were also purchased in the Company's name for \$21,000 on behalf of the following: 700 shares for Mr. Sterious, 200 shares for Dr. Constantine, 200 shares for FMR and 1,000 shares for Sterling. The Company received substantially all of such \$21,000 purchase price prior to the actual payment and was promptly reimbursed for the balance.

In early February 1969, Mr. Sterious brought to the attention of Messrs. Woike and Decosimo, then the other two members of the Company's investment committee, an initial public offering of Integrated Resources, Inc. ("Integrated Resources"), an unaffiliated company. An investment on the part of the Company was declined. On February 24, 1969, Mr. Sterious purchased 3,000 shares of Integrated Resources in the name of the Company for his own account. He did not advise the officers of the Company of this purchase. That same day he issued his check to the Company for the \$45,000 purchase price, whereupon the Company issued its check in payment for the shares. On February 28, 1969, following the successful public offering of Integrated Resources, the investment committee reconsidered its position and purchased 1,000 shares for the Company through its broker-dealer at \$30 per share. These shares were subsequently sold in October 1970 at a profit of \$4,498. Mr. Sterious gave 1,800 of his shares to his father, and commencing on May 4, 1970, sold his remaining 1,200 shares at an aggregate profit of \$18,534.

The Company has adopted a policy under which it will not purchase any securities other than for its own account or the account of one of its subsidiaries and will not advance funds to, or on behalf of, any of its officers or directors in connection with the purchase of securities or any other transaction.

PRINCIPAL SHAREHOLDER

The following table sets forth, as of May 31, 1971, the number of shares of Common Stock owned beneficially, and to be owned beneficially after the sale of the shares offered hereby, by Mr. Arthur DeMoss, the only person owning of record, or to the knowledge of the Company beneficially, more than 10% of the outstanding shares of the Company's Common Stock, and by all directors and officers of the Company as a group:

	Shares owned	Percent of class	Shares to be owned	Percent of class to be owned
Arthur DeMoss ¹	7,084,245	80.6	7,084,245	76.2
All directors and officers as a group ²	7,278,512	82.8	7,260,912	78.1

¹ Of the shares shown as being owned beneficially by Mr. DeMoss, 7,069,738 are held of record and 14,507 are held by his wife and by family trusts. They do not include shares owned by National Liberty Foundation of Valley Forge, Inc., of which Mr. DeMoss is president, a director and the principal contributor. His address is Valley Forge, Pa. See note 2 to the table under "Selling shareholders."

² The shares shown as being owned by all officers and directors as a group do not include shares held by them as fiduciaries for others or owned beneficially by their spouses or minor children, or shares owned by National Liberty Foundation of Valley Forge, Inc., and National Group Incentive Corp. See "Selling shareholders."

On the basis of the foregoing, Mr. DeMoss may be deemed to be a "parent" of the Company, as that term is defined in the regulations under the Securities Act of 1933.

SELLING SHAREHOLDERS

The following table sets forth, as of May 31, 1971, the number of shares of Common Stock owned and to be sold by the Selling Shareholders:

Name and address	Shares owned	Shares to be sold	Shares to be owned
National Liberty Foundation of Valley Forge, Inc., Valley Forge, Pa.1.....	115,388	60,000	55,388
National Group Incentive Corp., ² Valley Forge, Pa.	166,666	69,068	97,598
Richard Woike ² 20 Moores Rd., Frazer, Pa.	26,930	12,500	14,430
William A. Patty ² 20 Moores Rd., Frazer, Pa.	10,000	4,000	6,000
Floyd J. Campbell, 1622 Stephens Dr., Wayne, Pa.	3,202	2,000	1,202
Decosimo Family, 822 James Blvd., Signal Mountain, Tenn.: ..			
Joseph F. Decosimo	12,333	1,100	11,233
Sarah Angeline Decosimo	200	200	-----
Rachel Vincent Decosimo	200	200	-----
John Thomas Decosimo	200	200	-----
Rose Ellen Decosimo	200	200	-----
Mary Adelaide Decosimo	200	200	-----
M. Cessna Decosimo	200	200	-----
Patricia Louise Decosimo	200	200	-----
Sterious Family, 144 Conestoga Rd., Malvern, Pa.: ..			
John G. and Stephanie Sterious	6,137	1,700	4,437
John C. Sterious	400	400	-----
Deborah A. Sterious	400	400	-----
Former shareholders of National Home: ..			
Melissa Ann Chamberlain, 9 Oakleigh Lane, St. Louis, Mo.	5,407	300	5,107
Philip L. Chamberlain, 9 Oakleigh Lane, St. Louis, Mo.	717	100	617
William R. and Emily Alice Dunham, 4242 Lindell Blvd., St. Louis, Mo.	1,790	600	1,190
Judith H. Engelsmann, 4242 Lindell Blvd., St. Louis, Mo.	5,889	1,400	4,489
McVeigh Goodson, 19 Pointer Lane, St. Louis, Mo.	4,890	300	4,590
Joseph F. Hickey II, 4242 Lindell Blvd., St. Louis, Mo.	3,314	800	2,514
Meiissa McKay Hickey, successor trustee for J. F. Hickey II, 625 S. Skinker Blvd., St. Louis, Mo.	2,577	600	1,977
Hickey-Mitchell Co., ³ 4242 Lindell Blvd., St. Louis, Mo.	61,101	15,000	46,101
Raymond E. Kuester, 38 Middlesex Dr., St. Louis, Mo.	9,600	2,400	7,200
Jewish Hospital of St. Louis, 216 S. Kingshighway, St. Louis, Mo.	1,122	1,122	-----
Mercantile Insurance Agency, ³ 4242 Lindell Blvd., St. Louis, Mo.	12,810	12,810	-----
St. Louis Union Trust Co., trustee U/I Marie A. Hoskins, 510 Locust St., St. Louis, Mo.	5,351	1,000	4,351
Althea H. Schumacher, ³ 4242 Lindell Blvd., St. Louis, Mo.	34,529	9,000	25,529
Althea H. Schumacher, ³ trustee for F. Carl Schumacher, Jr., 4242 Lindell Blvd., St. Louis, Mo.	3,514	900	2,614
Althea H. Schumacher, ³ trustee for Nancy S. Dennis, 4242 Lindell Blvd., St. Louis, Mo.	1,757	800	957
F. Carl Schumacher, ³ 4242 Lindell Blvd., St. Louis, Mo.	1,449	300	1,149
Total shares to be sold		200,000	-----

¹ "See note 1 to the table under "Principal shareholder."

² National Group Incentive Corp., is owned one-third each by Messrs. Woike, Patty and Decosimo, directors of the company. Most of the proceeds from the sale of the shares being sold by it will be used to reduce a debt from that corporation to Mr. DeMoss. Shares shown as owned by Messrs. Woike, Patty and Decosimo do not include shares owned by that corporation.

³ Mrs. Schumacher owns 50 percent of the common stock of Hickey-Mitchell Co., and is a coexecutrix and beneficiary of the estate of Joseph F. Hickey, which owns 40.4 percent of the common stock of Mercantile Insurance Agency. The state of Joseph F. Hickey also owns 52 percent of the common stock of a company which owns 20 percent of the common stock of Mercantile Insurance Agency. Mrs. Schumacher's shareholdings include shares owned beneficially, whether or not of record, but do not include shares owned by members of Mrs. Schumacher's family. Mr. Schumacher is a director of the company.

DESCRIPTION OF COMMON STOCK

The holders of the Company's Common Stock, \$1 par value, are entitled to receive such dividends as may be declared by the Company's board of directors from funds legally available therefor. In the agreement pursuant to which the Company's 5½% Convertible Subordinated Debentures were issued, the Company is restricted as to the declaration and payment of dividends (other than dividends payable in its capital stock). See "Dividends" and Note 5 to Consolidated Financial Statements of National Liberty Corporation and Subsidiary Companies.

Holders of Common Stock are entitled to one vote for each share and to vote cumulatively for directors. In liquidation the holders of Common Stock are entitled to share pro-rata in all assets of the Company after payment or provision for payment of all liabilities of the Company and any amounts due holders of preferred stock. Holders of Common Stock do not have pre-emptive rights.

The presently issued and outstanding shares of Common Stock are, and the shares of Common Stock offered by the Company hereunder, when issued and

paid for, will be validly issued, fully paid and nonassessable. In the opinion of Dechert Price & Rhoads, counsel for the Company, all such shares will be exempt from presently existing personal property taxes in Pennsylvania. Bills have been introduced in the Pennsylvania Legislature which would make changes in the personal property tax laws and, if enacted into law, could subject the Company's Common Stock to a 4-mill County personal property tax applicable to shareholders residing in Pennsylvania.

The transfer agent for the Company's Common Stock is Girard Trust Bank, Philadelphia, Pa.

The Company will continue its present practice of issuing to its shareholders annual reports, including certified financial statements, and also intends to continue to issue quarterly reports containing unaudited financial data.

LITIGATION

National Liberty Life is contesting the imposition by the State of California of \$100,857 in additional premium taxes. This litigation is before the State Board of Equalization and was commenced July 7, 1969. In addition, National Liberty Life filed suit on September 29, 1970 in the Circuit Court of Dane County, Wisconsin to recover \$60,533 in premium taxes previously paid to the State of Wisconsin.

In March 1971, the Securities and Exchange Commission brought a civil suit in the Federal Court for the Eastern District of Pennsylvania against Utilities Leasing and against certain other companies and individuals, including John G. Sterious, who is president of NVC and a former vice president of the Company. See "Management—Certain Transactions". The complaint alleged, among other things, that the registration statement of that corporation, including the description of the Company's investment, was misleading and that Mr. Sterious was one of several persons who conspired to make it misleading. The Company is not a party to this litigation. Mr. Sterious entered into a consent decree, without admitting or denying the allegations, enjoining him from violating the Securities Act of 1933.

Irvin Fried and Thelma C. Fried brought a class action suit in January 1971 in the same court, making certain similar allegations, and have included the Company and Mr. Sterious as defendants. The plaintiffs' complaint does not set forth an amount of damages claimed.

UNDERWRITING

The Underwriters named below have severally agreed, subject to certain conditions, to purchase from the Company and the Selling Shareholders the aggregate number of shares of Common Stock set forth opposite their respective names below:

<i>Underwriter</i>	<i>Number of shares</i>
Smith, Barney & Co. Incorporated.....	82, 750
Kidder, Peabody & Co. Incorporated.....	82, 750
Blyth & Co. Inc.....	11, 000
Drexel Firestone Incorporated.....	11, 000
duPont Glore Forgan Incorporated.....	11, 000
Eastman Dillon, Union Securities & Co. Incorporated.....	11, 000
Goldman, Sachs & Co.....	11, 000
Hornblower & Weeks-Hemphill, Noyes.....	11, 000
Kuhn, Loeb & Co.....	11, 000
Lehman Brothers Incorporated.....	11, 000
Loeb, Rhoades & Co.....	11, 000
Paine, Webber, Jackson & Curtis Incorporated.....	11, 000
Salomon Brothers.....	11, 000
G. H. Walker & Co. Incorporated.....	11, 000
Bear, Stearns & Co.....	9, 500
A. G. Becker & Co. Incorporated.....	9, 500
Alex. Brown & Sons.....	9, 500
CBWL-Hayden, Stone Inc.....	9, 500
Clark, Dodge & Co. Incorporated.....	9, 500
Dominick & Dominick, Incorporated.....	9, 500
Equitable Securities, Morton & Co. Incorporated.....	9, 500

<i>Underwriter</i>	<i>Number of shares</i>
Robert Fleming Incorporated.....	9,500
E. F. Hutton & Company Inc.....	9,500
W. E. Hutton & Co.....	9,500
Kleinwort, Benson Incorporated.....	9,500
F. S. Moseley & Co.....	9,500
Paribas Corporation.....	9,500
Reynolds & Co.....	9,500
L. F. Rothschild & Co.....	9,500
Shearson, Hammill & Co. Incorporated.....	9,500
Shields & Company Incorporated.....	9,500
Singer, Deane & Scribner.....	9,500
Walston & Co., Inc.....	9,500
Wood, Struthers & Winthrop, Inc.....	9,500
J. C. Bradford & Co. Incorporated.....	7,000
Shelby Cullom Davis & Co.....	7,000
Estabrook & Co., Inc.....	7,000
Harris, Upham & Co. Incorporated.....	7,000
Legg, Mason & Co., Inc.....	7,000
Thomson & McKinnon Auchincloss Inc.....	7,000
Suez American Corporation.....	7,000
Tucker, Anthony & R. L. Day.....	7,000
Bacon, Whipple & Co.....	5,500
Ball, Burge & Kraus.....	5,500
Bateman Eichler, Hill Richards Incorporated.....	5,500
Boettcher and Company.....	5,500
Butcher & Sherrerd.....	5,500
Dain, Kalman & Quail Incorporated.....	5,500
R. S. Dickson, Powell, Kistler & Crawford.....	5,500
Elkins, Morris, Stroud & Co.....	5,500
First of Michigan Corporation.....	5,500
Janney Montgomery Scott Inc.....	5,500
Kohlmeyer & Co.....	5,500
Laird, Bissell & Meeds, Inc.....	5,500
Loewi & Co. Incorporated.....	5,500
McDonald & Company.....	5,500
Mitchum, Jones & Templeton Incorporated.....	5,500
Moore, Leonard & Lynch Incorporated.....	5,500
Prescott, Merrill, Turben & Co.....	5,500
Putnam, Coffin, Doolittle, Newburger—Division of Advest Co.....	5,500
Rauscher Pierce Securities Corporation.....	5,500
Reinholdt & Gardner.....	5,500
Shuman, Agnew & Co., Inc.....	5,500
Sutro & Co. Incorporated.....	5,500
Weis, Voisin & Co., Inc.....	5,500
Anderson & Strudwick.....	3,000
Boenning & Scattergood, Inc.....	3,000
DeHaven & Townsend, Crouter & Bodine.....	3,000
Edwards & Hanly.....	3,000
Hallowell, Sulzberger, Jenks & Co.....	3,000
Parker/Hunter Incorporated.....	3,000
H. O. Peet & Co., Inc.....	3,000
Raffensperger, Hughes & Co., Inc.....	3,000
Roose, Wade & Company.....	3,000
J. N. Russell Inc.....	3,000
Total	700,000

The Company and the Selling Shareholders have been advised by Smith, Barney & Co. Incorporated and Kidder, Peabody & Co. Incorporated, as Representatives (the "Representatives") of the several Underwriters, that the Underwriters propose to offer the shares to the public initially at the offering price set forth on the cover page hereof; that the Underwriters propose initially to allow a concession of not in excess of \$1.15 per share to certain dealers, including Underwriters; that the Underwriters and such dealers may initially allow a discount of not in

excess of 25 cents per share to other dealers; and that the public offering price and the concession and discount to dealers may be changed by the Representatives after the initial public offering.

The Selling Shareholders have agreed not to sell or otherwise dispose of any additional shares of Common Stock of the Company for a period of 90 days after the date of this Prospectus without the prior written consent of the Representatives.

Under the terms of the Underwriting Agreement, the several Underwriters will be obligated to purchase all of the shares, if any are purchased. The Company and certain Selling Shareholders have agreed to indemnify and, at their expense, to provide insurance indemnifying the Underwriters and others against certain civil liabilities, including liabilities under the Securities Act of 1933.

LEGAL OPINION

Legal matters in connection with the sale of the Common Stock offered hereby are being passed upon for the Company and certain Selling Shareholders by Dechert Price & Rhoads, Three Penn Center, Philadelphia, Pennsylvania 19102, for certain other Selling Shareholders by Stolar Heitzmann & Eder, 515 Oliver Street, St. Louis, Missouri 63101 and for the Underwriters by Sullivan & Cromwell, 48 Wall Street, New York, New York 10005, who may rely as to matters governed by Pennsylvania law upon the opinion of Dechert Price & Rhoads.

EXPERTS

The financial statements and schedules of (1) National Liberty Corporation and Subsidiary Companies, (2) National Liberty Life Insurance Company and Subsidiary and (3) National Liberty Corporation included in this Prospectus and elsewhere in the Registration Statement have been examined by Lybrand, Ross Bros. & Montgomery, independent certified public accountants, to the extent stated in their reports appearing herein or in the Registration Statement, and have been included in reliance upon such reports and on the authority of said firm as experts in accounting and auditing. The financial statements and schedules of National Home Life Assurance Company (not shown separately) utilized in the preparation of the aforementioned financial statements and schedules included in this Prospectus and elsewhere in the Registration Statement have been examined by Peat, Marwick, Mitchell & Co., independent certified public accountants, to the extent stated in their reports appearing herein or in the Registration Statement, and have been included in such statements in reliance upon such reports and on the authority of said firm as experts in accounting and auditing.

INDEX TO FINANCIAL STATEMENTS

Reports of Independent Certified Public Accounts.

National Liberty Corporation and Subsidiary Companies:

Consolidated Statement of Income for the years 1966 through 1970.

Notes to Consolidated Statement of Income.

Consolidated Balance Sheet as of December 31, 1970.

Consolidated Statement of Retained Earnings for the years 1966 through 1970.

Consolidated Statement of Source and Application of Cash for the years 1968 through 1970.

Notes to Consolidated Financial Statements.

National Liberty Life Insurance Company and Subsidiary:

Consolidated Balance Sheet as of December 31, 1970.

Consolidated Statement of Operations for the years 1966 through 1970.

Consolidated Statement of Surplus for the years 1966 through 1970.

Consolidated Statement of Source and Application of Cash for the years 1968 through 1970.

Notes to Consolidated Financial Statements.

National Liberty Corporation:

Balance Sheet as of December 31, 1970.

Statement of Income and Retained Earnings for the years 1968 through 1970.

Statement of Source and Application of Cash for the years 1968 through 1970.

Report of Independent Certified Public Accountants.

REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

National Liberty Corp.
Valley Forge, Pa.

We have examined (a) the consolidated balance sheet of National Liberty Corporation and subsidiary companies as of December 31, 1970 and the related consolidated statements of income and retained earnings for the five years then ended and the related consolidated statement of source and application of cash for the three years then ended, all of which have been restated prior to 1970 to reflect accounting changes with which we concur as described in Note 1 and (b) the consolidated balance sheet of National Liberty Life Insurance Company and subsidiary as of December 31, 1970 and the related consolidated statements of operations and surplus for the five years then ended and the related consolidated statements of source and application of cash for the three years then ended, all of which have been restated prior to 1970 to reflect accounting changes with which we concur as described in Note 1. Our examinations were made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We did not examine the financial statements of National Home Life Assurance Company, which statements were examined by other public accountants whose report thereon has been furnished to us. Our opinion expressed herein, insofar as it relates to the amounts included for said company, is based solely upon such report.

In our opinion, the aforementioned financial statements present fairly the respective consolidated financial positions of National Liberty Corporation and subsidiary companies and National Liberty Life Insurance Company and subsidiary at December 31, 1970 and the respective consolidated results of their operations for the five years then ended and the respective consolidated sources and applications of their cash for the three years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

LYBRAND, ROSS BROS. & MONTGOMERY.

Philadelphia, Pa.
March 25, 1971

Board of Directors
National Home Life Assurance Co.

We have examined the statement of assets and liabilities of National Home Life Assurance Company as of December 31, 1970, and the related statements of operations, retained earnings and additional paid-in and contributed capital for the five years then ended and the statement of source and use of funds for the three years then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting and actuarial records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, such financial statements (not presented separately herein) present fairly the financial position of National Home Life Assurance Company at December 31, 1970 and the results of its operations for the five years then ended, in conformity with generally accepted accounting principles applied on a consistent basis. Also, in our opinion, the aforementioned statement of source and use of funds (not presented separately herein) for the three years ended December 31, 1970 presents fairly the information set forth therein.

PEAT, MARWICK, MITCHELL & Co.

St. Louis, Mo.
March 10, 1971

NATIONAL LIBERTY CORP. AND SUBSIDIARY COMPANIES, CONSOLIDATED BALANCE SHEET, DEC. 31, 1970

Assets:	
Cash	\$5,138,214
Investments in securities:	
Insurance subsidiaries (note 2):	
Bonds	31,877,402
Preferred stocks	631,132
Common stocks	451,802
Total	32,960,336
Other, at cost:	
Commercial paper	440,294
Common stocks (quoted market value \$53,632)	96,290
Common stocks (restricted as to negotiability)	293,775
Total	830,359
First mortgage loans on real estate	1,626,076
Policy loans	1,391,735
Other receivables	1,099,812
Total	4,117,623
Premiums due and deferred	2,717,174
Property and equipment, at cost (note 3):	
Land	842,564
Home office buildings	7,253,919
Equipment	1,562,115
Total	9,658,598
Less accumulated depreciation	469,815
Total	9,188,783
Deferred policy acquisition costs (notes 1 and 4)	63,265,347
Other assets	4,935,959
Total	123,153,795
Liabilities:	
Policy reserves and unearned premiums	37,332,584
Claims and benefits payable	5,798,114
Notes payable and long-term debt, including current maturities of \$5,311,918 (note 5)	7,610,050
Accounts payable	3,214,592
Accrued expenses (principally solicitation expenses and premium taxes)	5,462,027
Income taxes (note 6):	
Current	22,706
Deferred	18,678,448
Total	18,701,154
Minority interest in subsidiaries	614,197
Total	78,732,718
Contingent liabilities (note 10)	
Shareholders' equity:	
Preferred stock, \$1 par value; 500,000 shares authorized; none issued.	
Common stock, \$1 par value; 12,500,000 shares authorized; issued and outstanding, 8,793,361 shares (notes 7, 8, and 12)	8,793,361
Capital in excess of par value (note 7)	2,864,465
Retained earnings (note 5)	32,763,251
Total	44,421,077
Grand total	123,153,795

NATIONAL LIBERTY CORP. AND SUBSIDIARY COMPANIES CONSOLIDATED STATEMENT OF RETAINED EARNINGS

	Year ended December 31—				
	1966	1967	1968	1969	1970
Balance at beginning of year, as restated (increased by \$3,553,010 as of Jan. 1, 1966) for companies acquired on a pooling of interests basis and adoption of principles contained in AICPA exposure draft—see note 1					
Net income	\$4,796,067	\$8,045,150	\$10,668,288	\$14,340,465	\$20,654,192
Dividends of pooled company prior to acquisition	3,259,583	2,913,138	3,672,177	6,313,727	12,109,059
Decrease resulting from capital transaction by pooled company prior to acquisition	(10,500)	(15,000)			
		(275,000)			
Balance at end of year	8,045,150	10,668,288	14,340,465	20,654,192	32,763,251

NATIONAL LIBERTY CORP. AND SUBSIDIARY COMPANIES CONSOLIDATED STATEMENT OF SOURCE AND APPLICATION OF CASH

	Year ended Dec. 31—		
	1968	1969	1970
Source of cash:			
Net income	\$3,672,177	\$6,313,727	\$12,109,059
Increase (decrease) due to changes in:			
Premiums due and deferred	35,709	(725,309)	(611,864)
Deferred policy acquisition costs	(6,670,030)	(11,636,318)	(20,509,567)
Other assets	(757,140)	11,588	(1,190,203)
Policy reserves and unearned premiums	4,439,088	6,313,352	6,505,359
Policy claim liabilities	293,346	1,095,836	59,453
Accounts payable and other liabilities	345,985	1,312,029	1,854,027
Deferred income taxes	2,476,301	3,782,569	4,410,336
Other adjustments:			
Investment (gains) and losses	(119,688)	167,047	762,639
Amortization of bond premium and discount	(1,631)	304	(33,508)
Depreciation	97,626	99,139	143,335
Amount	3,811,743	6,733,964	3,499,066
Increase in premiums received in advance	76,439	167,686	2,983
Increase in notes payable and long-term debt ¹	(5,006)	1,994,687	5,549,543
Proceeds from sale of investments	29,669,426	34,250,633	93,617,456
Proceeds from sale of common stock, net of expenses of \$559,091	5,330,909		
Other transactions, net	441,865	415,091	414,432
Amount	39,325,376	43,562,061	103,083,480
Application of cash:			
Increase (decrease) in mortgage and policy loans	(37,930)	(5,142)	415,385
Purchase of investments	37,706,279	39,385,852	96,358,514
Plant additions, net ¹	123,204	1,856,741	5,332,010
Repayment of advance from officer	500,000		
Expenses of merger		135,159	
	38,291,553	41,372,610	102,109,909
Net increase in cash	1,033,823	2,189,451	977,571
Cash balances:			
Jan. 1	937,369	1,971,192	4,160,643
Dec. 31	1,971,192	4,160,643	5,138,214

¹ The amounts netted against these captions are insignificant.

Note: See accompanying notes to consolidated financial statements.

A substantial portion of the sale and purchase of investments is made up of government notes, commercial paper, certificates of deposit and other short-term securities which were purchased and subsequently matured during the periods.

NATIONAL LIBERTY CORPORATION AND SUBSIDIARY COMPANIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Statement Presentation and Acquisitions:

National Liberty Corporation was incorporated in 1967 and in March 1968 exchanged 7,600,000 shares of its common stock for all the outstanding common stock of National Liberty Life Insurance Company, DeMoss Associates, Inc. and

Valley Forge Associates, Inc. In 1969, the Company acquired 99% of the outstanding capital stock of National Home Life Assurance Company in exchange for 429,312 shares of its common stock. These transactions were accounted for on a pooling of interests basis, and accordingly, the accompanying consolidated financial statements include the companies' results of operations prior to acquisition.

In 1969, the Company formed a subsidiary, National Information Systems Corporation, and purchased the majority of its outstanding Common Stock for \$360,000. In 1970, the Company formed National Consumer Marketing Corporation and National Venture Capital Corporation and purchased a majority of their outstanding Common Stock for an aggregate of \$530,000. The operations of these companies are included in the accompanying consolidated financial statements since their respective dates of incorporation.

The consolidated financial statements prior to 1970 have been retroactively restated from those previously presented as follows:

(1) Insurance subsidiaries, previously carried on a statutory or adjusted statutory equity basis, have been fully consolidated with other subsidiaries of the Company, and

(2) The accounts of the insurance subsidiaries have been adjusted in accordance with the principles contained in the exposure draft dated December 1970 prepared by the Committee on Insurance Accounting and Auditing of the American Institute of Certified Public Accountants entitled *Audits of Life Insurance Companies*. Such exposure draft has not been adopted.

For information with respect to statutory accounting practices of the insurance subsidiaries, see Note 2 to consolidated financial statements of National Liberty Life Insurance Company and Subsidiary.

In 1970, the Company (1) contributed its investment in National Home Life Assurance Company to National Liberty Life Insurance Company and (2) sold its investment in Valley Forge Associates, Inc. to National Consumer Marketing Corporation for \$1,000, an amount equivalent to its interest in the underlying equity therein.

Inasmuch as National Liberty Corporation carries its investments in subsidiaries on the equity basis, there is no difference between the investment in such subsidiaries, as shown on the parent's books, and the parent's equity in the net assets of such subsidiaries, as shown on the books of the latter.

The common stock and common stock per share data presented in the consolidated financial statements have been adjusted to reflect stock distributions and the increase in authorized shares approved in April 1971 as described in Note 12.

2. Bond and Stocks:

Bonds and stocks held by insurance subsidiaries are carried at values prescribed by the National Association of Insurance Commissioners. In general, bonds are stated at amortized cost, preferred stocks at cost and common stocks at market value. At December 31, 1970, the aggregate cost or amortized cost of such investments amounted to \$33,256,592 as compared with a related market value of \$29,036,042. Market value consists of quoted market value except for certain issues (principally private placements) in the aggregate amount of \$5,575,274 which are valued at cost or amortized cost and for which quoted market values are not available.

3. Property and Equipment:

Maintenance, repairs and minor renewals of property and equipment are charged to expense; major renewals and betterments which materially extend the life of such assets are capitalized. When depreciable assets are retired or sold, the related cost, net of accumulated depreciation and any sales proceeds, are reflected in income.

Depreciation is computed under the straight-line method over the following useful lives: home office buildings—30 to 50 years; equipment—5 to 20 years.

4. Policy Acquisition Costs:

Under the principles contained in the AICPA exposure draft (see Note 1) the Company amortizes policy acquisition costs principally over a twenty-year period using a declining balance method. Such method is based on the Company's persistency experience for the first five years, and actuarial tables thereafter. Prior to 1970, the Company amortized such costs over a three-year period at declining annual rates of 50%, 32% and 18%. For further information, see "Certain

Factors Affecting Accounting and Profits". An analysis of deferred policy acquisition costs for the three years ended December 31, 1970 is as follows:

	1968	1969	1970
Balance at beginning of year.....	\$24, 449, 433	\$31, 119, 463	\$42, 755, 781
Direct response business:			
Amounts deferred.....	8, 884, 882	14, 316, 047	26, 704, 263
Amortization.....	(2, 692, 647)	(3, 719, 340)	(5, 578, 372)
Other business:			
Increase (decrease) on life and agency business.....	477, 795	1, 039, 611	¹ (616, 325)
Balance at end of year.....	31, 119, 463	42, 755, 781	63, 265, 347

¹ Includes \$1,200,561 of costs written off against extraordinary gain in statement of income.

5. Notes Payable and Long-Term Debt:

At December 31, 1970, notes payable and long-term debt consisted of the following:

6¾% short-term bank notes payable.....	\$5, 250, 000
5¾% convertible subordinated debentures.....	2, 000, 000
Sundry other long-term debt.....	360, 050
Total	7, 610, 050

The 5¾% convertible subordinated debentures are subordinated to any allowable funded debt which the Company may incur in the future. The debentures are convertible into common stock at \$21.60 per share (subject to anti-dilution provisions), and 92,592 shares of common stock have been reserved for this purpose. Terms of the debentures provide, among other things, for (1) repayment of \$100,000 annually commencing on December 15, 1979 and each year thereafter to December 15, 1983 with the balance of \$1,500,000 due December 15, 1984, (2) redemption in whole or in part, at the option of the Company, at 105¾% of the principal amount to December 15, 1972, and at lesser amounts to December 15, 1983, and without premium thereafter, and (3) certain restrictions on the payment of cash dividends, repurchase of capital stock and the amount of funded debt that the Company may incur. At December 31, 1970, approximately \$5,600,000 of consolidated retained earnings are free of restriction with respect to the payment of cash dividends on common stock.

The aggregate principal amount of maturities for the five years following December 31, 1970 are as follows: 1971—\$5,311,918; 1972—\$78,520; 1973—\$79,425; 1974—\$64,138 and 1975—\$17,659.

6. Federal and Deferred Income Taxes:

As explained in Note (c) to the consolidated statement of income, deferred income taxes relate principally to the difference in reporting policy acquisition costs for financial and tax purposes.

For tax purposes, at December 31, 1970, net operating loss carry-forwards of approximately \$13,446,000 are available to offset future taxable income, if any, and expire as follows: \$1,546,000 in 1972, \$1,900,000 in 1973, \$1,600,000 in 1974 and \$8,400,000 in 1975.

The Company and its 80% or more owned subsidiaries, except insurance subsidiaries, file a consolidated federal income tax return. The provisions for income tax of the insurance subsidiaries are not proportional to their pre-tax financial statement income due to various exclusions and special deductions, etc. afforded such companies under the Internal Revenue Code. For further information with respect to income taxes of the insurance subsidiaries, see Note 5 to the consolidated financial statements of National Liberty Life Insurance Company and Subsidiary.

7. Common Stock and Capital In Excess of Par Value:

The changes in the common stock and capital in excess of par value accounts from 1968 (the year the Company first issued its common stock—see Note 1) to December 31, 1970 are as follows:

	Common stock		Capital in excess of par value
	Shares	Amount	
Balances, Jan. 1, 1968 (before adjustment for companies subsequently acquired on a pooling of interests basis and subsequent stock distributions)	1,000	\$1,000	-----
Issuance of stock in exchange for common stock of National Liberty Life Insurance Co., DeMoss Associates, Inc., and Valley Forge Associates, Inc., accounted for on a pooling of interests basis	3,800,000	3,800,000	-----
Sales of stock, net of expenses of \$559,091	380,000	380,000	\$4,950,909
Balance, Dec. 31, 1968	4,181,000	4,181,000	4,950,909
Issuance of stock in exchange for capital stock of National Home Life Assurance Co. accounted for on a pooling of interests basis, net of expenses of \$135,159 (see note 1)	214,656	214,656	1,428,703
Sale of common stock by National Information Systems Corp. (see note 1)	240	240	440,174
Issuance of stock upon exercise of qualified stock options	879,133	879,133	2,861
Transfer in connection with 6 for 5 stock distribution			(879,133)
Balance, Dec. 31, 1969	5,275,029	5,275,029	5,943,514
Transfer in connection with 5 for 4 stock distribution	1,318,792	1,318,792	(1,318,792)
Increase resulting from acquisition of a company by issuance of common stock of a majority-owned subsidiary			423,483
Issuance of stock upon exercise of qualified stock options	1,200	1,200	14,600
Balance, Dec. 31, 1970	6,595,021	6,595,021	5,062,805
Adjustment for transfer in connection with 4 for 3 stock distribution in 1971 (see note 12)	2,198,340	2,198,340	(2,198,340)
Balance, Dec. 31, 1970	8,793,361	8,793,361	2,864,465

8. Stock Options and Stock Purchase Plan:

The Company's qualified stock option plan provides for the granting of options to key employees to purchase its common stock at not less than current market prices on the date of grant. Options are exercisable at various annual rates from date of grant and expire five years thereafter. Information with respect to options granted under the plan is as follows:

	Number of shares	Option price		Market value	
		Per share	Total	Per share	Total
Shares under option at Dec. 31, 1970:					
Year of grant:					
1968-----	19,000	\$7.75-\$10.88	\$166,000	¹ \$7.75-\$10.88	\$166,000
1969-----	11,666	14.10- 23.70	202,725	¹ 14.10- 23.70	202,725
1970-----	19,017	18.75- 22.80	397,955	¹ 18.75- 21.19	365,895
Total-----	49,683		766,680		734,620
Options became exercisable:					
1968-----	3,800	7.75-10.88	42,600	² 7.75-10.88	42,600
1969-----	6,135	14.10-23.70	73,145	² 14.07-19.16	108,822
1970-----	6,135	18.75-22.80	73,145	² 18.71-27.60	132,779
Total-----	16,070		188,890		284,201
Options exercised:					
1968-----					
1969-----	400	7.75	3,101	³ 15.30	6,120
1970-----	1,600	7.75-16.25	15,800	³ 19.88	31,800
Total-----	2,000		18,901		37,920

¹ At date options were granted.

² At date options became exercisable.

³ At date options were exercised.

At December 31, 1970, options for 11,849 shares are exercisable in the future contingent upon certain performance standards and 54,084 shares are reserved for options which have not yet been granted. No charges are made to income in connection with the plan.

The Company's majority-owned subsidiary, National Information Systems Corporation (NIS), has a similar qualified stock option plan under which, at December 31, 1970, options to purchase 120,191 shares have been granted and

37,380 shares are reserved for options which have not yet been granted. In addition NIS has 2,857 shares reserved for issuance under non-transferable warrants.

Beginning in 1969, the Company instituted a Stock Purchase Plan under which eligible employees may elect to have a percentage of their compensation (not to exceed 8%) withheld through payroll deductions. Depending upon earnings, the consolidated companies match from 25% to 100% of each participant's contribution. All funds in the Plan are used to purchase the Company's common stock in the open market. Charges to income with respect to the Plan aggregated \$29,980 and \$66,891 in 1969 and 1970, respectively.

9. Profit Sharing and Pension Plans:

Effective January 1, 1969, the Company adopted an "Employees Profit-Sharing Plan" under which the Company and qualified subsidiaries contribute a portion of their consolidated income before income taxes as determined by the Company's Board of Directors, not to exceed 15% of the aggregate compensation of plan members. Contributions charged to income under the plan amounted to \$83,395 for 1969 and \$131,249 for 1970. Eligible employees may also contribute a portion of their compensation to the plan.

During the years 1969 to 1970, National Home had a pension plan which resulted in a pension expense of \$43,571 in 1966, \$45,691 in 1967, \$51,201 in 1968, \$38,180 in 1969, and \$12,000 in 1970, including amortization of prior service cost over a period of fifteen years. Effective January 1, 1971, the plan is being terminated and integrated into the "Employees Profit-Sharing Plan".

10. Leases:

At December 31, 1970, the Company and its subsidiaries leased premises and data processing equipment for various terms at aggregate annual rentals of approximately \$889,000.

11. Supplementary Profit and Loss Information:

	Charged to operating expense	Charged to other accounts	Total
1968:			
Maintenance and repairs.....	\$24, 875		\$24, 875
Depreciation.....	97, 626		97, 626
Taxes other than income:			
Premium taxes.....	793, 715		793, 715
Other.....	270, 190	\$15, 601	285, 791
Rents.....	183, 449	18, 349	201, 798
1969:			
Maintenance and repairs.....	43, 529		43, 529
Depreciation.....	99, 139		99, 139
Taxes, other than income:			
Premium taxes.....	693, 746		693, 746
Other.....	333, 885	22, 249	356, 134
Rents.....	554, 325	38, 892	593, 217
1970:			
Maintenance and repairs.....	66, 657		66, 657
Depreciation.....	143, 335		143, 335
Taxes, other than income:			
Premium taxes.....	1, 005, 825		1, 005, 825
Other.....	410, 297	40, 131	450, 428
Rents.....	1, 066, 832	48, 545	1, 115, 377

There were no management and service contract fees or royalties paid during the above periods.

12. Subsequent Events:

On February 9, 1971, the Board of Directors of the Company adopted resolutions providing for (1) an increase in the authorized common stock from 7,500,000 shares to 12,500,000 shares and (2) a stock distribution by the issuance of one share of common stock for each three shares of common stock held of record on April 28, 1971. These resolutions were approved at the annual shareholders' meeting on April 27, 1971.

The Company's subsidiary, National Home, has entered into a contract providing for the reinsurance (with right to assume) of certain accident and health policies. See "Insurance Operations—Recent Event" elsewhere in the Prospectus.

NATIONAL LIBERTY LIFE INSURANCE CO. AND SUBSIDIARY

Consolidated balance sheet, Dec. 31, 1970

Assets:	
Bonds (note 3)	\$31, 877, 402
Stocks (note 3) :	
Preferred	631, 132
Common	451, 802
Total	1, 082, 934
1st mortgage loans on real estate	1, 626, 076
Policy loans	1, 391, 735
Cash	4, 204, 476
Accident and health premiums due and unpaid	1, 451, 307
Life insurance premiums deferred and uncollected	1, 265, 867
Investment income due and accrued	451, 317
Property and equipment, at cost :	
Land	734, 113
Home office buildings	7, 253, 919
Equipment	530, 943
Total	8, 518, 975
Less accumulated depreciation	215, 886
Total	8, 303, 089
Deferred policy acquisition costs (notes 1 and 2)	35, 686, 115
Other assets	370, 282
Total assets	87, 710, 600
Liabilities :	
Aggregate reserves and unearned premiums (note 4) :	
Accident and health policies	27, 027, 347
Life policies	10, 258, 005
Total	37, 285, 352
Supplementary contracts without life contingencies and dividend accumulations	47, 232
Total	37, 332, 584
Policy and contract claims (note 4)	5, 798, 114
Other policyholders' funds :	
Premiums received in advance	684, 691
Other	6, 312
Total	691, 003
Deferred Federal income taxes (note 5)	9, 069, 239
Other liabilities :	
Premium and other taxes	1, 557, 340
Commissions to affiliate	1, 627, 659
General expenses	809, 416
Amounts held for agents	96, 827
Miscellaneous liabilities	424, 410
Total	4, 515, 652
Minority interest in subsidiary	115, 250
Total liabilities	57, 521, 842
Contingent liabilities (note 9)	

NATIONAL LIBERTY LIFE INSURANCE CO. AND SUBSIDIARY—Continued
CONSOLIDATED BALANCE SHEET DEC. 31, 1970.—Continued

Shareholders' equity:

Common stock, \$1 par value; shares authorized, issued and outstanding—1,500,000 (notes 6 and 7)-----	\$1,500,000
Capital in excess of par value (notes 6 and 7)-----	3,245,620
Surplus, as annexed-----	25,443,138
Total shareholders' equity-----	30,188,758
Total liabilities and shareholders' equity-----	87,710,600

NATIONAL LIBERTY LIFE INSURANCE CO. AND SUBSIDIARY CONSOLIDATED STATEMENT OF OPERATIONS

	Year Ended December 31				
	1966	1967	1968	1969	1970
Premiums:					
Accident and health-----	\$21,349,097	\$25,117,226	\$25,340,556	\$25,485,967	\$40,856,030
Life-----	7,130,508	7,235,258	8,167,848	8,843,580	5,879,872
Reinsurance assumed-----	2,588	15,756	1,193,005	7,515,693	7,215,295
Total premiums-----	28,482,193	32,368,240	34,701,409	41,845,240	53,951,197
Investment income:					
Interest, principally bonds-----	715,499	976,694	1,232,853	1,792,025	2,730,601
Dividend income-----	74,893	70,890	67,689	68,694	40,670
Real estate income-----		22,500	83,390	92,196	90,096
Total investment income-----	790,392	1,070,084	1,383,932	1,952,915	2,861,367
Investment expenses-----	45,800	118,945	143,621	152,678	167,627
Net investment income-----	744,592	951,139	1,240,311	1,800,237	2,693,740
Total-----	29,226,785	33,319,379	35,941,720	43,645,477	56,644,937
Accident and health, death, and other benefits-----	13,703,149	16,036,455	15,526,570	18,377,206	20,388,136
Increase in aggregate reserves for all policies-----	3,355,109	2,050,446	4,117,745	3,260,376	6,902,022
Total-----	17,058,258	18,086,901	19,644,315	21,637,582	27,290,158
Balance-----	12,168,527	15,232,478	16,297,405	22,007,895	29,354,779
Commissions:					
Affiliate (note 8)-----	5,865,180	6,352,063	6,303,095	8,529,126	14,089,408
Others-----	1,389,416	2,661,992	2,871,124	3,122,884	2,154,332
Total-----	7,254,596	9,014,055	9,174,219	11,652,010	16,243,740
General insurance expenses (note 8)-----	4,417,747	5,883,637	4,809,209	5,174,523	15,316,006
Taxes, licenses and fees-----	462,230	570,370	673,496	1,001,476	1,265,358
Increase in loading and cost of collection on deferred and uncollected premiums-----	174,884	36,398	11,669	116,887	45,103
Increase in deferred policy acquisition costs (notes 1 and 2)-----	(2,797,287)	(1,618,700)	(595,904)	(3,228,169)	(15,447,762)
Total-----	9,512,170	13,885,760	14,072,689	14,716,727	17,422,445
Income from underwriting and investment-----	2,656,357	1,346,718	2,224,716	7,291,168	11,932,334
Dividends to policyholders—life (note 10)-----	31,988	34,883	38,437	38,963	46,271
Income from operations before provision for income taxes, etc.-----	2,624,369	1,311,835	2,186,279	7,252,205	11,886,063
Provision for deferred income taxes (note 5)-----	595,372	192,397	535,701	1,964,565	2,948,625
Income from operations before investment gains (losses) and extraordinary gain-----	2,028,997	1,119,438	1,650,578	5,287,640	8,937,438
Investment gains (losses), net of related deferred income taxes-----	410	196,839	79,688	(167,047)	(682,948)
Income before extraordinary gain. Extraordinary gain on sale of portfolio of insurance, net of related deferred income taxes of \$1,082,958-----	2,029,407	1,316,277	1,730,266	5,120,593	8,254,490
Net income-----	2,029,407	1,316,277	1,730,266	5,120,593	11,608,216

Note: See accompanying notes to consolidated financial statements.

NATIONAL LIBERTY LIFE INSURANCE CO. AND SUBSIDIARY CONSOLIDATED STATEMENT OF SURPLUS

	Year ended December 31—				
	1966	1967	1968	1969	1970
Balance at beginning of year, as restated (increased by \$5,158,668 as of Jan. 1, 1966) for company accounted for on a pooling of interests basis and adoption of principles contained in AICPA ex- posure draft (see note 1).....	\$5,276,129	\$7,295,036	\$8,321,313	\$9,214,329	\$13,834,922
Net income, as annexed.....	2,029,407	1,316,277	1,730,266	5,120,593	11,608,216
Cash dividends on preferred stock, \$3 per share.....	(10,500)	(15,000)			
Par value of 3,500 shares of preferred stock and 2,500 shares of common stock (par value per share \$10) issued to holders of common stock in re- capitalization.....		(200,000)			
Par value of 1,500 shares of preferred stock issued as dividends to holders of common stock.....		(75,000)			
Transfer to capital in connection with recapitalization (note 6).....			(837,250)	(500,000)	
Balance at end of year.....	7,295,036	8,321,313	9,214,329	13,834,922	25,443,138

NATIONAL LIBERTY LIFE INSURANCE CO. AND SUBSIDIARY CONSOLIDATED STATEMENT OF SOURCE AND APPLICATION OF CASH

	Year ended December 31—		
	1968	1969	1970
Source of cash:			
Net income.....	\$1,730,266	\$5,120,593	\$11,608,216
Increase (decrease) due to changes in:			
Premiums due and deferred.....	84,144	(773,744)	(611,864)
Deferred policy acquisition costs.....	(595,904)	(7,489,969)	(14,247,201)
Other assets.....	(279,450)	(235,197)	221,341
Policy reserves and unearned premiums.....	4,439,088	6,313,352	6,505,359
Policy claim liabilities.....	293,346	1,095,836	59,453
Commissions payable and other liabilities.....	164,657	702,070	2,036,671
Deferred income taxes.....	575,701	1,964,565	3,920,583
Other adjustments:			
Investment (gains) and losses.....	(119,688)	167,047	762,639
Amortization of bond premium and discount.....	(1,631)	304	(33,508)
Depreciation.....	110,639	44,821	41,972
Amount.....	6,401,168	6,859,678	10,263,661
Increase in premiums received in advance.....	76,439	167,686	2,983
Proceeds from sale of investments.....	29,668,926	33,981,641	92,105,978
Capital contributions by parent.....	445,743	891,487	
Total.....	36,592,276	41,900,492	102,372,622
Application of cash:			
Increase (decrease) in mortgage and policy loans.....	(37,930)	(5,142)	415,385
Purchase of investments.....	35,601,852	38,929,183	96,295,414
Plant additions, net ¹	162,007	1,468,804	4,779,587
Total.....	35,725,929	40,392,845	101,490,386
Net increase in cash.....	866,347	1,507,647	882,236
Cash balances:			
January 1.....	948,264	1,814,593	3,322,240
December 31.....	1,814,593	3,322,240	4,204,476

¹ The amounts netted against this caption are insignificant.

Note: See accompanying notes to consolidated financial statements.

A substantial portion of the sale and purchase of investments is made up of government notes, commercial paper, certificates of deposit and other short-term securities which were purchased and subsequently matured during the periods.

NATIONAL LIBERTY LIFE INSURANCE COMPANY AND SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Statement Presentation:

The consolidated financial statements include the accounts of National Liberty Life Insurance Company (National Liberty Life) and its subsidiary, National Home Life Assurance Company (National Home). In 1969, National Liberty Corporation (parent of National Liberty Life) acquired 99% of the outstanding capital stock of National Home in a pooling of interests transaction and in 1970 it contributed its investment in National Home to National Liberty Life. Accordingly, the accompanying consolidated financial statements include the operations of National Home prior to its acquisition.

In addition, the financial statements of National Liberty Life and National Home were retroactively adjusted in 1970 in accordance with the principles contained in the exposure draft dated December 1970 prepared by the Committee on Insurance Accounting and Auditing of the American Institute of Certified Public Accountants (AICPA) entitled *Audits of Life Insurance Companies*. Such exposure draft has not been adopted.

As a result of the foregoing, net income previously reported has been adjusted as follows:

	1966	1967	1968	1969
Net income as originally reported.....	\$417,394	\$1,412,166	\$3,466,790	\$4,225,647
Retroactive adjustment resulting from pooling of interests of National Home.....	(221,546)	(767,592)	(201,432)	305,732
Net income as adjusted, statutory basis.....	195,848	644,574	3,265,358	4,531,379
Retroactive adjustment, resulting from adoption of principles contained in AICPA exposure draft.....	1,833,559	671,703	(1,535,092)	589,214
Net income as reported in accompanying consolidated statement of operations.....	2,029,407	1,316,277	1,730,266	5,120,593

As a result of the pooling of interests of National Home, premium income and net investment income previously reported has been adjusted as follows:

	1966	1967	1968	1969
Premium income:				
As previously reported.....	\$16,333,572	\$22,075,882	\$24,306,111	\$30,253,629
Retroactive adjustment, resulting from pooling of interests of National Home.....	12,148,621	10,292,358	10,395,298	11,591,611
As reported in accompanying consolidated statement of operations.....	28,482,193	32,368,240	34,701,409	41,845,240
Net investment income:				
As previously reported.....	397,718	610,355	890,253	1,362,523
Retroactive adjustment, resulting from pooling, of interests of National Home.....	346,874	340,784	350,058	437,714
As reported in accompanying consolidated statement of operations.....	744,592	951,139	1,240,311	1,800,237

For information with respect to statutory accounting practices of the insurance companies, see Note 2.

2. Statutory Accounting Practices:

The financial statements of National Liberty Life and National Home filed with the insurance departments of their respective states of domicile are prepared in accordance with the practices prescribed or permitted by such regulatory authorities which differ in certain respects from the principles employed in preparing the accompanying consolidated financial statements. The differences are (1) financial statements of the companies, which are presented on a separate company basis for statutory purposes, have been consolidated, (2) policy acquisition costs, which are charged against operations as incurred for statutory purposes, have been deferred and amortized over the periods benefited, (3) policy reserves, which are stated principally on modified reserve methods for statutory purposes, have been restated on a net level basis using revised assumptions (assumed interest averaged approximately 5%), (4) certain assets designated as "nonadmitted", which are excluded from the balance sheet for statutory purposes, have been restored (the term "nonadmitted" assets means assets other than assets which are permitted to be reported to regulatory authorities), (5) the contingency reserve, "Mandatory Securities Valuation Reserve", which is required to be shown as a liability for statutory purposes, has been restored to surplus, (6) investment gains and losses, which are reflected in surplus for statutory purposes, have been reflected in income, (7) deferred taxes, which are not recognized for statutory purposes, have been provided and (8) extraordinary items and certain transactions required to be shown in surplus for statutory purposes have been reflected in income or capitalized. A reconciliation of net gain from operations and surplus as shown in the accompanying financial statements with statutory amounts (on a consolidated basis) is as follows:

	1966	1967	1968	1969	1970
Net income as reported in the accompanying consolidated statement of operations.....	\$2,029,407	\$1,316,277	\$1,730,266	\$5,120,593	\$11,608,216
Increase in deferred policy acquisition costs.....	(2,797,287)	(1,618,700)	(595,904)	(3,228,169)	(15,447,762)
Increase in policy reserves.....	1,525,121	911,233	1,656,581	451,404	1,240,691
Tentative ceding commissions under reinsurance agreements.....	(1,084,441)				
Provision for deferred income taxes.....	595,372	192,397	535,701	1,964,565	2,948,625
Extraordinary gain.....					(3,353,726)
Investment (gains) losses.....	(410)	(196,839)	(79,688)	167,047	682,948
Miscellaneous.....	(71,914)	40,206	18,402	55,939	301,296
Net gain (loss) from operations (statutory basis).....	195,848	644,574	3,265,358	4,531,379	(2,019,712)
Surplus as reported in the accompanying consolidated statement of surplus.....	7,295,036	8,321,313	9,214,329	13,834,922	25,443,138
Deferred policy acquisition costs.....	(11,734,341)	(13,353,041)	(13,948,945)	(21,438,114)	(35,686,115)
Policy reserves.....	2,797,716	3,708,949	5,365,532	7,177,936	8,251,842
Deferred income taxes.....	2,344,993	2,608,390	3,184,091	5,148,656	9,069,239
Nonadmitted assets.....	(348,415)	(329,749)	(404,891)	(536,309)	(746,079)
Nonstatutory adjustments to extraordinary gain.....					(2,081,505)
Miscellaneous.....	(284,284)	(540,256)	(606,460)	(484,433)	(826,496)
Surplus (statutory basis).....	70,705	415,606	2,803,656	3,702,658	3,424,024

3. Bonds and Stocks:

Bond and stock valuations have been determined in accordance with methods prescribed by the National Association of Insurance Commissioners. Accordingly, the admitted asset values as shown in the accompanying balance sheet principally consist of amortized cost with respect to bonds, cost with respect to preferred stocks, and market value with respect to common stocks. A summary of investments at December 31, 1970 is as follows:

	Actual cost	Book value	Quoted market value	Admitted asset and financial statement value
Bonds:				
U.S. Government.....	\$676,862	\$678,009	\$651,840	\$678,009
Special revenue.....	2,489,782	2,491,432	2,172,117	2,488,232
Railroad.....	1,724,034	1,731,159	1,547,342	1,731,159
Public utilities.....	7,962,368	7,928,759	7,116,206	7,928,759
Industrial and miscellaneous.....	19,163,424	19,056,243	16,709,513	19,051,243
Total bonds.....	32,016,470	31,885,602	28,197,018	31,877,042
Stocks:				
Preferred:				
Railroad.....	238,344	238,344	98,390	159,592
Public utilities.....	305,428	305,428	173,693	305,428
Banks.....	10,000	10,000	5,200	10,000
Industrial and miscellaneous.....	172,966	172,966	110,299	156,112
Total preferred stocks.....	726,738	726,738	387,592	631,132
Common:				
Public utilities.....	273,515	273,515	245,000	245,000
Industrial and miscellaneous.....	371,737	370,737	206,802	206,802
Total common stocks.....	645,252	644,252	451,802	451,802
Total stocks.....	1,371,990	1,370,990	839,384	1,082,934
Total bonds and stocks.....	33,388,460	33,256,592	29,036,402	32,960,336

Market value consists of quoted market values except for certain issues (principally private placements) in the aggregate amount of \$5,575,274 which are valued at cost, or amortized cost, and for which quoted market values are not available.

4. Policy Reserves and Claims:

The aggregate reserves for all policies, on a statutory basis, at December 31, 1970 were determined on the following standards:

	Amount
Accident and health policies:	
Unearned premium based on monthly pro rata factors.....	\$11,499,712
Additional reserves for guaranteed renewable policies, two-year preliminary term method (1956 hospital and surgical tables—1941 CSO, 2½%).....	7,778,952
Present value of amounts not yet due on claims.....	751,680
Total	20,030,344

Life policies:

A. E. 3½% Illinois Std.....	473,615
CSO Commissioners' Reserve Valuation Method:	
1941:	
2½%.....	956,018
3%.....	480,333
1958:	
2½%.....	557,447
3%.....	2,158,876
3½%.....	1,581,300
1949 Annuity table—3½%.....	357,661
1951 Group annuity—3½%.....	174,000
1941 CSO, net level—2½%.....	987,470
1958—CSO, net level:	
3%.....	744,097
3½%.....	196,620
Others	335,729

Total 9,003,166

Total reserves (statutory basis)..... 29,033,510

Adjustment to net level basis using revised assumptions
(see notes 1 and 2)..... 8,251,842

Aggregate reserves as shown in accompanying balance
sheet 37,285,352

The liability for policy claims on accident and health business at December 31, 1970 is based upon (1) an estimated average cost per claim for losses reported to such date and (2) estimates of unreported losses based on past experience. Policy claim liability for life policies is the actual face amount of the policies for which claims have been made. At December 31, 1970 there was no reinsurance deducted in respect of the companies' policy claim liability.

5. Federal Income Taxes:

For income tax purposes, the companies charge policy acquisition costs to income as incurred, while for financial reporting purposes such costs are deferred and amortized over periods benefited. Deferred income taxes relate principally to the difference in reporting these costs for financial and tax purposes.

At December 31, 1970, accumulated earnings for federal income tax purposes includes approximately \$3,057,000 of "Policyholders' Surplus" as defined under the Life Insurance Company Tax Act of 1959. Under the provisions of the Act, "Policyholders' Surplus", of which \$461,000 arose in 1968, \$455,000 in 1969 and \$244,000 in 1970, has not been currently taxed but would be taxed at current rates if distributed. If the total amount of "Policyholders' Surplus" had been subject to tax at December 31, 1970, such tax would have amounted to \$1,504,000 of which \$227,000 would apply to 1968, \$244,000 to 1969 and \$120,000 to 1970. The companies have no present intentions to make cash distributions from "Policyholders' Surplus." Data with respect to "Policyholders' Surplus" recomputed under generally accepted accounting principles are as follows:

	Amount	Related tax
Balance at Dec. 31, 1970.....	\$18, 168, 000	\$8, 939, 000
Portion of balance which arose in:		
1968.....	1, 256, 000	618, 000
1969.....	3, 466, 000	1, 705, 000
1970.....	6, 859, 000	3, 375, 000

At December 31, 1970, net operating loss carry-forwards of approximately \$1,000,000 are available to offset future taxable income, if any, and expire in 1975.

6. Recapitalization:

On March 18, 1968, the Board of Directors of National Liberty Life approved the issuance of 612,750 shares of its common stock for the then issued and outstanding shares of capital stock as follows:

- (a) 600,000 shares for the 15,000 shares of \$10 par value common stock and
- (b) 12,750 shares for the 8,500 shares of \$50 par value preferred stock.

The excess of \$412,250 of the par value of the preferred stock retired over the par value of the common stock issued was added to capital in excess of par value. The aggregate difference in the par value of the common stock exchanged in the amount of \$450,000 was transferred from surplus to common stock.

On August 1, 1968, and January 28, 1969, the Board of Directors of National Liberty approved the issuance of 387,250 and 500,000 shares, respectively, of \$1 par value common stock to National Liberty Corporation, and the capitalization of equivalent amounts of surplus.

7. Common Stock and Capital in Excess of Par Value:

The changes in the common stock and capital in excess of par value accounts since January 1, 1966 are as follows:

	Common stock		Capital in excess of par value
	Shares	Amount	
Balances, Jan. 1, 1966 and 1967.....	12, 500	\$125, 000	\$150, 000
Par value of shares issued in recapitalization by charge to surplus.....	2, 500	25, 000	
Balances, Dec. 31, 1967.....	15, 000	150, 000	150, 000
Transfer in connection with recapitalization (note 6).....	985, 000	850, 000	412, 250
Balances, Dec. 31, 1968.....	1, 000, 000	1, 000, 000	562, 250
Transfer in connection with recapitalization (note 6).....	500, 000	500, 000	
Balances, Dec. 31, 1969.....	1, 500, 000	1, 500, 000	562, 250
Contribution to capital of investment in National Home Life Assurance Co. by parent (note 1).....			2, 683, 370
Balances, Dec. 31, 1970.....	1, 500, 000	1, 500, 000	3, 245, 620

8. Transactions with Affiliates:

DeMoss Associates, Inc. (DeMoss Associates), an affiliated general agency, incurs costs in connection with the solicitation of prospective policyholders for National Liberty Life and National Home. Prior to September 1, 1970, on policies written through DeMoss Associates, the companies paid DeMoss Associates commissions of 50% on the first year business and 20% on the renewal business. On September 1, 1970 in the case of National Home, and January 1, 1971 in the case of National Liberty Life, the companies began to market directly in certain jurisdictions, paying DeMoss Associates a fee for its marketing services. During the last four months of 1970 approximately 85% of National Home's solicitations (other than agency business) were made directly at a cost of \$8,621,576, and DeMoss Associates' commissions were equivalent to approximately 7½% of first year business and 3% of renewal business.

During the years 1966 to 1968, National Liberty Life received amounts from DeMoss Associates, principally for the use of data processing equipment and programming services. In January 1969, National Liberty Life sold its data processing equipment and related software to National Information Systems Corporation (NIS), an affiliate, for an amount equivalent to the carrying value of such equipment. The companies subsequently entered into contracts with NIS to provide them with data processing services. The companies also were charged in 1969 and 1970 by National Liberty Corporation for administrative services.

On July 1, 1969, National Liberty Life paid DeMoss Associates \$2,900,000 in connection with its reinsurance of certain accident and health policies solicited by DeMoss Associates for other insurance companies.

9. Reinsurance:

The companies follow the practice of reinsuring portions of their life insurance risks with other companies. Ceded life insurance risks approximated \$63,000,000 at December 31, 1970 and the companies would be liable for such risks in the event the reinsuring companies are unable to pay their portion of the risks.

Premium income of approximately \$1,200,000 in 1968, \$6,500,000 in 1969, and \$6,000,000 in 1970 is applicable to accident and health reinsurance assumed by National Liberty Life.

10. Participating Life Insurance Policies:

Dividends on such policies, as shown in the Consolidated Statement of Operations, are paid at the discretion of the Board of Directors of the companies from earnings derived from the participating policies themselves.

11. Subsequent Event:

National Home has entered into a contract providing for the reinsurance (with right to assume) of certain accident and health policies. See "Insurance Operations—Recent Event" elsewhere in this Prospectus.

NATIONAL LIBERTY CORP.

Balance sheet, Dec. 31, 1970

Assets:

Cash	\$509,389
Marketable securities, at cost (quoted market value \$8,000)	26,001
Accounts receivable from subsidiaries	77,786
Investments in subsidiaries, at equity in adjusted net assets	41,148,764
Advances to subsidiaries	9,735,179
Other assets	220,949
Total assets	51,718,068

Liabilities:

Notes payable and long term debt including current maturities of \$5,250,000 (note 5)	7,250,000
Accounts payable	27,471
Accrued expenses	19,520

NATIONAL LIBERTY CORP.—Continued

Balance sheet, Dec. 31, 1970—Continued

Shareholders' equity:

Preferred stock, \$1 par value; 500,000 shares authorized, none issued	
Common stock, \$1 par value; 12,500,000 shares authorized; issued and outstanding, \$8,793,361 shares (notes 7, 8 and 12)	\$8,793,361
Capital in excess of par value (note 7)	2,864,465
Retained earnings, including \$32,916,444 of undistributed earnings of subsidiaries (note 5)	32,763,251
Total	44,421,077
Total liabilities and shareholders' equity	51,718,068

STATEMENT OF INCOME AND RETAINED EARNINGS

	Year ended December 31—		
	1968	1969	1970
Interest and other investment income:			
From subsidiaries	\$190,106	\$329,891	\$1,053,012
Other	5,408	25,001	49,602
General and administrative expense	(190,480)	(350,970)	(1,264,763)
Income (loss) from operations	5,034	3,922	(162,149)
Equity in undistributed income of subsidiaries	3,667,143	6,309,805	12,271,208
Net income	3,672,177	6,313,727	12,109,059
Retained earnings at beginning of year	10,668,288	14,340,465	20,654,192
Retained earnings at end of year	14,340,465	20,654,192	32,763,251

Note: See accompanying notes to consolidated financial statements of National Liberty Corp., and subsidiary companies.

NATIONAL LIBERTY CORP. STATEMENT OF SOURCE AND APPLICATION OF CASH

	Year ended December 31—		
	1968	1969	1970
Source of cash:			
Net income	\$3,672,177	\$6,313,727	\$12,109,059
Deduct equity in undistributed income of subsidiaries	(3,667,143)	(6,309,805)	(12,271,208)
Amount	5,034	3,922	(162,149)
Proceeds from sale in 1968 of common stock (net of related expenses of \$559,091) and exercise of stock options	5,330,909	3,101	15,800
Repayment of advances by consolidated subsidiaries		1,699,197	1,151,673
Increase in notes payable and long-term debt ¹		2,000,000	5,250,000
Increase (decrease) in other liabilities	85,851	79,189	(118,049)
Amount	5,421,794	3,785,409	6,137,275
Application of cash:			
Increase in investment in consolidated subsidiaries ¹		1,251,487	533,000
Advances to consolidated subsidiaries	5,273,197	1,993,000	5,319,852
Increase (decrease) in other assets and other transactions net	125,295	337,974	(130,875)
Expenses of merger		135,159	
Amount	5,398,492	3,717,620	5,718,977
Net increase in cash	23,302	67,789	418,298
Cash balances:			
January 1		23,302	91,091
December 31	23,302	91,091	509,389

¹ The amounts netted against these captions are insignificant.

Note: See accompanying notes to consolidated financial statements of National Liberty Corp. and subsidiary companies.

REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

National Liberty Corporation
Valley Forge, Pennsylvania

We have examined the balance sheet of National Liberty Corporation as of December 31, 1970 and the related statements of income, retained earnings and source and application of cash for the three years then ended, all of which have been restated prior to 1970 to reflect accounting changes with which we concur as described in Note 1 to the consolidated financial statements of National Liberty Corporation and subsidiary companies. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We did not examine the financial statements of National Home Life Assurance Company, which statements were examined by other public accountants whose report thereon has been furnished to us. Our opinion expressed herein, insofar as it relates to the amounts included for said company, is based solely upon such report.

In our opinion, the aforementioned financial statements, when read in conjunction with the consolidated financial statements and related notes of National Liberty Corporation and subsidiary companies for the three years ended December 31, 1970, present fairly the financial position of National Liberty Corporation at December 31, 1970 and the results of its operations and the source and application of its cash for the three years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Philadelphia, Pa.
March 25, 1971

LYBRAND, ROSS BROS. & MONTGOMERY.

NATIONAL LIBERTY CORP.

Cross reference sheet

<i>Number and item</i>	<i>Heading in prospectus</i>
1. Distribution spread-----	Cover page.
2. Plan of distribution-----	Cover page: underwriting.
3. Use of proceeds to registrant-----	Use of proceeds.
4. Sales otherwise than for cash-----	(¹)
5. Capital structure-----	Capitalization.
6. Summary of earnings-----	Consolidated statement of income.
7. Organizations of registrant-----	National Liberty Group.
8. Parents of registrant-----	Principal shareholder.
9. Description of business-----	National Liberty Corp.; National Liberty Group; insurance operations; noninsurance subsidiaries.
10. Description of property-----	Property.
11. Organization within 5 years-----	National Liberty Group.
12. Pending legal proceedings-----	Litigation.
13. Capital stock being registered-----	Description of common stock.
14. Long term debt being registered-----	(¹)
15. Other securities being registered-----	(¹)
16. Directors and executive officers-----	Management.
17. Remuneration of directors and Officers-----	Do. Do.
18. Options to purchase securities-----	Principal shareholder; selling shareholders.
19. Principal holders of securities-----	
20. Interest of management and others in certain transactions-----	Noninsurance subsidiaries; management.
21. Financial statements-----	Index to financial statements.

¹ Omitted because item is not applicable.

REGISTRATION STATEMENT PART II

INFORMATION NOT REQUIRED IN PROSPECTUS

Item 23. Other Expenses of Issuance and Distribution.

The following table sets forth the estimated expenses in connection with the offering described in the Registration Statement.

	To be paid by the company	To be paid by certain of the selling shareholders	Total
Registration statement filing fee.....	\$4,400	\$1,200	\$5,600
Legal fees and expenses.....	58,700	16,300	75,000
Accounting fees and expenses.....	72,700	20,300	93,000
Transfer agent's fees and expenses.....	3,000	-----	3,000
Printing expenses.....	53,200	14,800	68,000
Blue sky fees and expenses (including legal fees and disbursements).....	5,900	1,600	7,500
Securities act indemnity insurance.....	38,100	11,900	50,000
Total.....	236,000	66,100	302,100

Item 31. Financial Statements and Exhibits.

(b) Exhibits:

<i>Exhibit No.</i>	<i>Description</i>
1-----	Revised form of Agreement Among Underwriters, including revised Underwriting Agreement.
6-----	Opinion of Dechert Price & Rhoads as to legality of securities being registered.
Consent filed herewith:	
	Consent of Dechert Price & Rhoads (contained in its opinion filed as Exhibit 6 hereto)

SIGNATURES

----- the requirements of the Securities Act of 1933, National Liberty Corporation, Registrant, ----- this Amendment to its Registration Statement to be signed on its behalf by the under- ----- duly authorized, in Frazer, Commonwealth of Pennsylvania, on the 26th day of -----.

NATIONAL LIBERTY CORPORATION,
By ARTHUR DEMOSS.
(Arthur DeMoss, President)

----- the requirements of the Securities Act of 1933, this Amendment to the Registration ----- been signed below by the following persons in the capacities indicated on the 26th day of -----.

<i>Signature</i>	<i>Title</i>
ARTHUR DEMOSS (Arthur DeMoss)	President and Director; principal executive officer.
W. BENJAMIN WEAVER (W. Benjamin Weaver)	Vice President and Treasurer; principal financial and accounting officer.
JOHN W. KELLER (John W. Keller)	Director.
WILLIAM A. PATTY (William A. Patty)	Director.
CARL G. SEMPIER (Carl G. Sempeir)	Director.
CHARLES M. CAVANAGH (Charles M. Cavanagh)	Director.
WILLIAM H. SHIPLEY (William H. Shipley)	Director.
RICHARD WOIKE (Richard Woike)	Director.

CONSENT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

We consent to the inclusion of the following reports in the Registration Statement to be used in registering, under the Securities Act of 1933, 700,000 shares of common stock of National Liberty Corporation:

(1) Our reports dated March 25, 1971 accompanying the financial statements of National Liberty Corporation and subsidiary companies, National Liberty Life Insurance Company and subsidiary and National Liberty Corporation, which are included in the Prospectus.

(2) Our report dated March 25, 1971 accompanying the supporting schedules listed in Item 31(a) of the Registration Statement.

We also consent to the reference to our Firm under the captions "Consolidated Statement of Income" of National Liberty Corporation and subsidiary companies and "Experts" in the Prospectus.

Philadelphia, Pa.

LYBRAND, ROSS BROS. & MONTGOMERY.

July 27, 1971

ACCOUNTANTS' CONSENT AND REPORT ON SCHEDULES

Board of Directors

National Home Life Assurance Company

The examination referred to in our report dated March 10, 1971, included the related supporting schedules for the three years ended December 31, 1970, included in the Registration Statement. In our opinion, such schedules (not presented separately herein) present fairly the information set forth therein.

We consent to the use of our report included herein and to the reference to our firm under the heading "Experts" in the Prospectus.

St. Louis, Missouri

PEAT, MARWICK, MITCHELL & Co.

July 27, 1971

NATIONAL LIBERTY CORPORATION AND SUBSIDIARY COMPANY, SCHEDULE XIII CAPITAL STOCK, AS OF DEC. 31, 1970

Col. A, name of issuer and title of issue ¹	Col. B, number of shares authorized by charter	Col. C, number of shares issued and not retired or canceled	Col. D, number of shares included in col. C which are—		Col. E, shares outstanding as shown on or included in related balance sheet under caption "Common stock"		Col. F, number of shares held by affiliates for which state- ments are filed herewith		Col. G, number of shares reserved for officers and employees	Col. H, number of shares reserved for options, warrants, conversions, and other rights
			Held by or for account of issuer thereof	Not held by or for account of issuer thereof	Number	Amount at which carried	Persons included in consolidated statements	Others		
National Liberty Corp : Preferred stock, \$1 par value.....	500,000	None	None	None	None	None	None	None	None	None
Common stock, \$1 par value.....	12,500,000	8,793,361	None	8,793,361	8,793,361	\$8,793,361	None	None	None	197,259
National Information Systems Corp : Common stock, without par value, stated value \$0.05 per share.....	5,000,000	3,132,652	None	3,132,652	732,652	36,633	None	None	None	160,428
National Consumer Marketing Corp : Common stock, without par value, stated value \$0.05 per share.....	3,000,000	1,800,000	None	1,800,000	200,000	10,000	None	None	None	None
National Venture Capital Corp : Common stock, without par value, stated value \$1 per share.....	500,000	495,000	None	495,000	45,000	45,000	None	None	None	None
						<u>8,884,994</u>				
Shown on balance sheet as:										
Common stock.....						8,793,361				
Minority interest in common stock.....						<u>91,633</u>				
						<u>8,884,994</u>				

¹ There has been omitted from this schedule the information with respect to the capital stock of all consolidated wholly-owned subsidiaries. The answers in cols. G and H in respect to such subsidiaries would be "none".

NATIONAL LIBERTY LIFE INSURANCE CO. AND SUBSIDIARY, SCHEDULE VII. LIFE INSURANCE POLICY PRESERVES, BENEFITS AND INSURANCE IN FORCE

	Dec. 31, 1968			Dec. 31, 1969			Dec. 31, 1970		
	Ordinary life	Group life	Total	Ordinary life	Group life	Total	Ordinary life	Group life	Total
Policy reserves (statutory basis):									
Additions:									
Tabular net premiums	\$3, 873, 324	\$2, 109, 869	\$5, 983, 193	\$5, 241, 535	\$2, 366, 893	\$7, 608, 428	\$3, 663, 056	\$1, 043, 340	\$4, 706, 396
Tabular interest	226, 274	25, 739	252, 013	258, 799	11, 284	270, 083	277, 680	12, 328	290, 008
Other	250, 957	-----	250, 957	89, 393	523	89, 916	54, 040	-----	54, 040
Total	4, 350, 555	2, 135, 608	6, 486, 163	5, 589, 727	2, 378, 700	7, 968, 427	3, 994, 776	1, 055, 668	5, 050, 444
Deductions:									
Tabular cost	2, 414, 048	2, 058, 103	4, 472, 151	3, 621, 167	2, 387, 090	6, 008, 257	1, 418, 494	891, 822	2, 310, 316
Reserves released	524, 140	44, 154	568, 294	669, 022	13, 103	682, 125	1, 474, 329	138, 645	1, 612, 297
Annuity, supplementary contracts and other payments	279, 690	-----	279, 690	148, 733	-----	148, 733	124, 362	-----	124, 362
Total	3, 217, 878	2, 102, 257	5, 320, 135	4, 438, 922	2, 400, 193	6, 839, 115	3, 017, 185	1, 030, 467	4, 047, 652
Increase (decrease) in policy reserves	1, 132, 677	33, 351	1, 166, 028	1, 150, 805	(21, 493)	1, 129, 312	977, 591	25, 201	1, 002, 792
Policy reserves at beginning of period	5, 451, 931	253, 103	5, 705, 034	6, 584, 608	286, 454	6, 871, 062	7, 735, 413	284, 961	8, 000, 374
Policy reserves at end of period (note A)	6, 584, 608	286, 454	6, 871, 062	7, 735, 413	264, 961	8, 000, 374	8, 713, 004	290, 162	9, 003, 166
Death and other benefits	1, 536, 780	1, 636, 012	3, 172, 792	1, 952, 276	2, 184, 117	4, 136, 393	1, 184, 379	952, 106	2, 136, 485
Insurance in force	855, 116, 097	237, 993, 395	1, 093, 109, 492	970, 508, 319	352, 936, 693	1, 323, 445, 012	605, 945, 682	206, 952, 345	812, 898, 027
Note A:									
Policy reserves at end of period, as above			6, 871, 062			8, 003, 374			9, 003, 166
Adjustment to net level basis using revised assumptions			877, 387			1, 297, 856			1, 294, 839
Policy reserves at end of period included in the accompanying financial statements			7, 748, 449			9, 298, 230			10, 258, 005

NATIONAL LIBERTY LIFE INSURANCE COMPANY AND SUBSIDIARY, SCHEDULE VII, ACCIDENT AND HEALTH PREMIUMS, LOSSES, UNDERWRITING EXPENSES AND RESERVES,
FOR THE YEARS ENDED DEC. 31, 1970, 1969, AND 1968

Description (A)	Unearned premiums beginning of period (B)	Net premiums written (C)	Unearned premiums end of period (D)	Premiums earned during period (E)	Losses incurred during period (F)	Loss expense incurred during period (note A) (G)	Commissions incurred during period (notes B and C) (H)	Other underwriting expense in- curred during period (notes B and C) (I)	Statutory guaranteed renewable reserve at end of period (note D) (J)	Present value of amounts not yet due on claims (K)
Accident and health: Year ended Dec. 31:										
1970.....	\$8,987,531	\$49,303,917	\$11,499,712	\$46,791,736	\$18,229,241	-----	\$14,287,493	\$14,787,120	\$7,778,952	\$751,680
1969.....	34,443,467	8,987,531	8,987,531	31,907,330	14,289,028	-----	9,555,781	4,501,471	6,407,578	1,813,140
1968.....	6,451,394	26,833,317	6,451,394	26,503,823	12,411,733	-----	7,236,563	3,441,136	5,027,680	507,380

Note A.—Amounts pertaining to loss expense are included in col. 1.

Note B.—Exclusive of amounts allocated to life insurance business as follows:

	Commissions	Underwriting expense	
Year ended Dec. 31:			
1970.....	\$1,956,247	\$1,589,531	
1969.....	2,056,229	1,622,061	
1968.....	1,937,656	2,022,300	
Guaranteed renewable reserves, as above.....			
Adjustment to net level basis using revised assumptions.....			
	\$7,778,952	\$6,407,578	\$5,027,680
Guaranteed renewable reserves as included in the accompanying financial statements.....			
Unearned premiums, as above.....			
Present value of amounts not yet due on claims, as above.....			
Accident and health reserves.....			
	27,027,347	23,089,128	16,733,271

Note C.—Does not include increase in deferred policy acquisition costs of \$15,477,762, \$3,228,169 and \$595,904 for years ended Dec. 31, 1970, 1969 and 1968, respectively.

Note D.—The reconciliation of statutory reserves with those included in the accompanying financial statements is as follows:

THE 50 LARGEST

COMMERCIAL BANKING COMPANIES

[Ranked by assets, dollars in thousands]

Rank	Bank		Assets ¹		Deposits		Loans		Employees ³		Net income ⁴	
	1970	1969	1970	1969	1970	1969	1970	1969	1970	1969	1970	1969
1	1	1	\$29,739,902	\$25,643,215	1	1	\$16,592,828	1	35,600	2	\$163,878	1
2	2	2	25,835,455	21,012,779	3	2	15,266,682	2	37,000	1	139,294	2
3	3	3	24,525,703	21,227,395	2	3	13,928,999	3	25,154	3	117,337	3
4	4	4	12,664,865	11,072,080	4	4	7,993,511	4	12,793	7	77,599	5
5	5	5	12,112,419	9,576,337	6	5	5,902,351	7	8,142	13	88,609†	4
6	6	6	11,409,817	9,692,308	5	6	6,396,652	5	25,861	4	54,222††	7
7	7	7	10,979,483	8,981,478	7	8	6,176,568	6	12,523	8	67,927	6
8	8	8	9,930,646	8,575,155	8	7	5,157,995	8	13,394	6	55,667	12
9	9	9	8,863,550	7,154,144	9	9	4,442,524	11	8,207	12	57,304	7
10	10	10	8,038,070	7,033,487	10	10	4,514,724	10	15,111	5	54,765	9
11	11	11	8,028,398	6,269,480	11	11	4,622,211	9	5,758	20	49,546	11
12	12	12	7,637,701	5,990,601	12	13	3,829,903	13	11,086†	9	43,436	13
13	13	13	6,308,634	5,256,571	13	12	2,659,389	16	6,579	17	27,110	21
14	14	14	6,225,566	5,254,183	14	14	3,900,595	12	10,900	10	32,731	19
15	15	15	6,032,451	4,843,039	15	15	3,174,622	15	9,511	11	34,176	18
16	16	16	5,669,869	4,748,102	16	16	3,378,548	14	4,592	23	45,453	12
17	17	17	5,175,322	4,000,463	17	17	2,524,499	17	5,213†	22	36,447	16
18	18	18	4,732,712	3,624,161	20	19	2,408,841	10	7,062	15	41,608	14
19	19	19	4,406,229	3,883,581	19	20	2,344,228	20	6,280†	19	40,763	15
20	20	20	4,341,674	3,739,213	18	18	2,466,821	18	7,868	14	34,269	17
21	21	21	3,494,144	2,967,066	22	24	1,916,850	22	3,862	30	21,767	25
22	22	22	3,287,717	2,916,385	23	22	1,930,479	21	6,325	18	29,570	20
23	23	23	3,149,275	2,717,004	21	21	1,496,565	26	5,394	21	22,375	24

24	Unionamerica (Los Angeles)	2,677,618	2,154,812	25	30	1,463,113	27	30	3,959	20	17,189	37	38
25	Cleveland Trust	2,643,194	2,284,411	24	23	1,631,333	23	23	3,455	36	26,001	23	20
26	Republic National Bank of Dallas	2,580,861	1,770,474	33	33	1,604,043	24	29	1,654†	48	18,650	33	30
27	PNB Corp. (Philadelphia)	2,554,460	2,038,891	27	26	1,413,876	28	25	3,070	39	21,138	26	29
28	Seattle-First National Bank	2,548,663	1,974,803	29	28	1,550,638	25	28	4,209	25	19,214	19	27
29	Girard Co. (Philadelphia)	2,522,465	2,096,655	26	29	1,201,537	34	31	3,245	37	16,051	32	31
30	Wachovia Corp. (Winston-Salem)	2,300,242	1,468,268	43	42	1,410,813	29	44	7,029	16	26,288	22	31
31	Detroit Bank & Trust	2,260,913	2,013,330	28	25	1,306,663	31	26	2,711	44	18,914	31	26
32	First Wisconsin Bankshares (Milwaukee)	2,220,042	1,926,288	30	31	1,109,443	39	43	3,753	33	16,597	38	40
33	National Bank of North America (New York)	2,196,962	1,852,360	32	27	1,127,857	33	27	3,965	28	20,347	28	36
34	Manufacturers National Bank of Detroit	2,150,790	1,913,479	31	28	1,314,301	30	39	2,491	45	12,989	46	45
35	Northern Trust (Chicago)	2,072,807	1,741,448	34	36	1,190,163	35	40	2,424	46	19,064	30	34
36	First National Bank in Dallas	2,071,574	1,594,309	40	40	1,119,106	38	37	1,362	50	17,605	36	39
37	Harris Trust & Savings Bank (Chicago)	2,052,430	1,678,756	36	41	1,050,356	41	38	2,906	41	18,671	32	33
38	Pittsburgh National Corp.	1,988,589	1,657,296	37	35	945,003	46	42	2,725	43	21,021	27	25
39	Lincoln First Banks (Rochester, N.Y.)	1,976,811	1,711,656	35	32	1,228,710	32	33	3,758	32	14,728	42	37
40	Bank of California (San Francisco)	1,916,144	1,643,545	38	34	1,078,382	40	36	3,856	31	6,922	49	50
41	Valley National Bank (Phoenix)	1,851,156	1,600,720	39	39	1,127,725	37	34	4,132	26	13,962	43	43
42	Citizens & Southern National Bank (Atlanta)	1,830,175	1,378,859	44	43	1,180,158	36	32	4,400	34	18,399	34	35
43	U.S. Bancorp (Portland, Oregon)	1,759,388	1,536,550	41	37	1,028,162	42	35	3,998	27	12,833	46	45
44	Bank Ohio (Columbus)	1,756,273	1,511,306	42	46	825,721	48	49	3,464	35	16,636	40	44
45	Shawmut Association (Boston)	1,681,696	1,345,259	45	48	885,563	47	47	3,719	34	11,684	47	48
46	NCNB Corp. (Charlotte)	1,678,030	1,288,352	49	50	978,606	44	48	3,700	38	13,516	44	47
47	Fidelity Corp. of Pennsylvania (Philadelphia)	1,625,303	1,326,181	47	44	998,572	43	41	2,925	40	15,200	41	41
48	National City Bank of Cleveland	1,594,058	1,292,575	48	45	725,771	50	46	1,517	49	18,136	35	28
49	National Bank of Commerce (Seattle) ³	1,527,900	1,330,692	46	47	823,791	49	50	2,793	42	9,654	48	49
50	Bank of the Commonwealth (Detroit)	1,491,540	1,049,425	50	49	964,324	45	45	1,770	47	(9,845)	50	42

Totals

278,079,682

230,364,917

153,604,715

369,705

1,764,751

Rank	1970	1969	Bank	Stockholders' equity ^a		Net income as per-cent of equity			Earnings per share ^b			Growth rate 1960-70 ^c	
				1970	1969	Per-cent	1970	1969	1970 (dol-lars) ^d	1960 (dol-lars) ^e	1960 (dol-lars) ^f	Per-cent	Rank
1			Bank America (San Francisco)	1	2	13.3	14	17	4.75	4.77	4.43	2.89	5.09
2			First National City Corp. (New York)	2	1	11.3	35	39	5.29	5.13	4.41	10 2.80	6.57
3			Chase Manhattan Corp. (New York)	3	3	10.8	38	40	4.17	3.68	4.93	2.36	5.86
4			Manufacturers Hanover Corp. (New York)	5	5	11.7	30	29	6.08	5.54	4.93	11 3.24	6.50
5			J. P. Morgan (New York)	4	4	11.5	33	33	5.57	4.73	3.81	12 2.86	6.89
6			Western Bancorporation (Los Angeles)	8	9	9.7	47	23	3.20	2.38	2.98	13 1.75	6.22
7			Chemical New York Corp.	6	6	10.8	39	35	5.71	5.06	4.47	3.22	5.90
8			Bankers Trust New York Corp.	12	12	12.1	27	43	5.28	5.43	3.99	3.63	3.82
9			Comill Corp. (Chicago)	9	8	10.6	40	47	3.77	3.37	2.77	14 2.07	6.18
10			Security Pacific National Bank (Los Angeles)	10	10	11.1	37	30	3.40	3.24	3.09	15 1.85	6.27
11			First Chicago Corp.	7	7	8.6	48	50	6.01	4.99	5.84	16 3.65	5.11
12			Marine Midland Banks (Buffalo)	13	13	11.9	29	20	3.44	3.40	3.70	17 3.11	4.84
13			Charter New York	20	21	10.4	42	44	3.69	3.59	3.35	18 3.11	4.72
14			Wells Fargo & Co. (San Francisco)	15	15	10.0	45	46	3.54	3.55	3.50	19 2.47	3.66
15			Crocker National Corp. (San Francisco)	19	19	12.7	22	31	3.19	3.27	3.03	20 2.32	3.24
16			Mellon National Bank & Trust (Pittsburgh)	11	11	9.7	46	48	5.06	4.55	4.24	21 2.48	7.39
17			National Bank of Detroit	17	17	12.5	25	25	6.51	6.07	5.59	22 3.03	7.95
18			First National Boston Corp.	14	14	11.6	31	37	6.93	6.93	5.75	23 3.69	6.53
19			First Bank System (Minneapolis)	16	16	13.7	9	24	5.60	5.58	4.68	24 2.21	9.74
20			Northwest Bancorporation (Minneapolis)	18	18	12.0	28	27	3.04	2.07	2.73	25 1.44	7.76
21			Franklin New York (Mineola, N.Y.)	35	31	15.8	2	3	4.70	4.31	3.89	26 2.31	7.36
22			First Pennsylvania Corp. (Philadelphia)	23	22	14.9	4	9	2.48	2.46	2.19	27 1.18	7.71
23			Bank of New York Co.	25	23	13.6	10	2	4.84	4.03	3.53	28 2.09	8.76
24			Unionamerican (Los Angeles)	40	39	14.2	5	15	4.17	4.14	3.55	29 1.95	7.60
25			Cleveland Trust	21	20	10.1	43	36	11.53	10.40	10.07	30 5.69	7.32
26			Republic National Bank of Dallas	27	27	13.5	6	18	2.02	1.99	1.50	31 1.07	6.56
27			PNB Corp. (Philadelphia)	37	30	14.1	13	22	4.09	3.90	3.28	32 1.88	8.08
28			Seattle-First National Bank	28	25	12.3	26	21	4.21	4.27	4.24	33 2.36	5.96
29			Girard Co. (Philadelphia)	39	36	12.9	19	12	6.43	6.27	6.21	34 3.31	9.41
30			Wachovia Corp. (Winston-Salem)	22	33	12.9	20	14	3.59	3.68	3.02	35 1.46	5

31	26	Detroit Bank & Trust	149,079	29	28	12.7	21	13	8.01	7.72	7.53	4.38	6.22	35
32	33	First Wisconsin Bankshares (Milwaukee)	132,498	36	34	12.5	24	32	3.86	3.94	3.55	1.62	9.07	9
33	33	National Bank of North America (New York)	144,563	40	43	14.1	7	6	3.71	3.71	3.16	1.27	11.32	3
34	31	Manufacturers National Bank of Detroit	100,350	45	44	12.9	18	19	6.80	6.33	5.71	3.54	6.75	27
35	31	Northern Trust (Chicago)	141,238	31	29	13.5	12	26	8.90	9.53	6.65	3.90	8.60	11
36	36	First National Bank in Dallas	127,789	38	35	13.8	8	28	3.60	3.64	2.60	1.51	9.08	8
37	32	Harris Trust & Savings Bank (Chicago)	186,688	24	24	10.0	44	42	7.36	7.47	6.03	3.95	6.42	33
38	34	Pittsburgh National Corp.	159,923	26	26	13.1	16	11	7.54	6.85	5.93	3.11	9.26	7
39	37	Lincoln First Banks (Rochester, N.Y.)	116,989	41	37	12.6	23	16	4.39	4.01	4.05	2.18	7.25	22
40	35	Bank of California (San Francisco)	80,978	49	49	8.5	49	49	2.57	2.37	2.28	0.73	0.81	49
41	42	Valley National Bank (Phoenix)	103,355	44	46	13.5	11	4	1.65	1.64	1.56	0.73	8.50	12
42	39	Citizens & Southern National Bank (Atlanta)	138,680	32	41	13.3	15	7	1.80	1.65	1.09	0.54	12.79	2
43	40	U.S. Bancorp (Portland, Oregon)	113,121	42	40	11.3	34	34	3.10	3.15	2.64	1.75	5.88	40
44	49	BankOhio (Columbus)	188,695	33	38	11.6	32	38	2.59	2.79	2.54	1.30	7.14	23
45	46	Shawmut Association (Boston)	110,655	43	42	10.6	41	45	5.81	5.98	5.78	23.45	5.35	42
46	43	NCHB Corp (Charlotte)	88,591	47	48	15.3	3	10	2.04	2.04	1.69	20.52	14.65	1
47	45	Fidelity Corp of Pennsylvania (Philadelphia)	95,109	46	45	16.0	1	5	3.87	3.80	2.57	1.59	9.30	6
48	44	National City Bank of Cleveland	138,374	34	32	13.1	17	8	6.36	5.56	4.57	2.91	8.13	13
49	50	National Bank of Commerce (Seattle)	85,595	48	47	11.3	36	41	24.05	24.14	21.77	12.08	7.13	24
50	47	Bank of the Commonwealth (Detroit)	54,587	50	50	-----	50	1	(1.78)	(2.54)	2.48	0.65	-----	50
Totals			15,216,263											

1 As of December 31, 1970.

2 Includes federal funds sold, U.S. securities purchased under agreements to resell, and mortgages.

3 Year-end total unless followed by a dagger (†), in which case average for the year.

4 Net income, after securities transactions and extraordinary items. A double dagger (‡) means that there was a charge representing at least 10 percent of the net income shown.

5 As of December 31, 1970.

6 Earnings per share have been computed as described in footnote 7, page 172.

7 Average annual growth rate compounded. The 1970 figure on which the growth rate is based is income before securities transactions but after a loan-loss provision. The figure for 1960, the base year, does not reflect any loan losses.

8 Income before securities transactions.

9 Net operating earnings.

10 First National City Bank and First National City Trust Co.

11 Manufacturers Trust Co.

12 Morgan Guaranty Trust.

13 Firstamerica Corp.

14 Continental Illinois National Bank & Trust.

15 Security First National Bank.

16 First National Bank of Chicago.

17 Irving Trust.

18 Wells Fargo Bank American Trust Co.

19 Crocker-Anglo National Bank.

20 First National Bank of Boston and Old Colony Trust.

21 First Bank Stock Corp.

22 Union Bank.

23 Philadelphia National Bank.

24 Girard Trust Corn Exchange Bank.

25 Meadow Brook National Bank.

26 Lincoln Rochester Trust.

27 United States National Bank.

28 National Shawmut Bank.

29 North Carolina National Bank.

30 Fidelity-Philadelphia Trust.

31 Bank is a subsidiary of Marine Bancorporation.

as an investment on its balance sheet, the figures shown are for the bank.

MAKING MONEY

While most other industries were hurt by last year's slowdown, banking provided further evidence of its ability to do well in just about any economic climate. The fifty largest banking companies—twenty-one of them are one-bank holding companies—made substantial gains in all the crucial financial categories. Assets for the group rose 11.5 percent, deposits 12.1 percent, loans outstanding 7.4 percent, and stockholders' equity 7.8 percent.

The companies also showed sharply higher earnings last year; however, a precise comparison with 1969 is not feasible because of a change in the way the figures have been computed. Last year's directory included earnings figures that did not take into account securities transportation, while 1970 figures—i.e., those headed "net income"—all include such transactions. The lists do make it possible to compare *per-share* earnings performance in the two years. With securities transactions included for both 1969 and 1970, all but five of the banks showed gains last year in earnings per share. (Among the 500 largest industrials, by comparison, a majority had lower earnings in 1970.) The median per-share performance of the banks was a fat 11.7 percent gain. The gain was accomplished despite heavy loan losses incurred by many banks in the wake of last year's "credit crisis."

There was one spectacularly poor performance. Detroit's Bank of the Commonwealth, which was a member of the troubled Parsons group, lost \$9,845,000, making it the first bank to show a deficit in the history of the list. (Chase Manhattan Corp. has since acquired a substantial interest in the bank.) Ironically, Bank of the Commonwealth, which had a disastrous run-in last year with federal regulators, had ranked first during 1969 in two categories: earnings as a percentage of capital funds and ten-year earnings-per-share growth.

The companies on the list are the same ones that appeared last year, although there has been some reshuffling. Wachovia Corp. made the greatest leap, going from forty-first to thirtieth in assets after it acquired American Credit Corp.

50 LARGEST—Continued

UTILITIES—Continued

[Ranked by assets, dollars in thousands]

Rank	1970	1969	Company	Assets ¹	Operating revenues ²		Net income ³		Stockholders' equity ⁴	
					1970	1969	1970	1969	1970	1969
36			Baltimore Gas & Electric	\$1,149,214	\$328,104	36	\$51,647	25	\$535,285	20
37			Pennsylvania Power & Light (Allentown)	1,140,512	255,313	44	34,935	44	459,492	28
38			New England Electric System (Westboro, Mass.)	1,091,924	323,818	37	29,076	48	289,682	48
39			Panhandle Eastern Pipe Line (Houston)	1,079,206	419,204	25	47,389	31	287,175	49
40			Potomac Electric Power (Washington, D.C.)	1,064,972	222,389	47	32,635	45	410,506	36
41			Long Island Lighting (Mineola)	1,040,399	300,881	39	42,370	36	441,436	30
42			Ohio Edison (Akron)	1,024,066	281,821	42	50,069	28	407,780	37
43			Wisconsin Electric Power (Milwaukee)	1,008,076	287,746	40	32,310	46	398,681	39
44			Houston Lighting & Power	963,818	287,752	41	53,851	23	390,589	40
45			Pacific Power & Light (Portland)	925,224	158,893	50	30,768	47	319,437	45
46			Gulfstates Utilities (Beaumont, Texas)	917,771	194,602	49	38,998	41	345,890	43
47	(u)		Carolina Power & Light (Raleigh)	884,850	204,846	48	24,825	49	345,370	44
48			Western Union (New York)	868,059	399,520	79	23,350	50	447,503	29
49			Cleveland Electric Illuminating	815,828	245,381	45	40,733	39	286,933	50
50			Illinois Power (Decatur)	804,893	230,433	46	42,022	37	293,736	47
Totals				131,846,198	40,665,405	-----	5,156,368	-----	53,668,389	-----

Rank	Company	Net income as percent of equity		Earnings per share ^a				Rank
		Per- cent	1970	1969	Employees ^b			Per- cen
					1970	1969	1960	
1	American Tel. & Tel. (New York)	9.0	36	39	772,980	\$3.99	\$4.00	35
2	Consolidated Edison (New York)	6.5	49	49	23,726	2.30	2.47	47
3	Pacific Gas & Electric (San Francisco)	9.2	35	33	23,369	2.47	2.58	23
4	Commonwealth Edison (Chicago)	11.3	18	17	14,089	2.95	3.00	31
5	American Electric Power (New York)	13.1	11	5	14,489	2.30	2.35	12
6	American Electric Power (Los Angeles)	9.3	33	44	12,299	2.70	2.70	21
7	Southern California Edison (Los Angeles)	11.1	21	19	16,883	1.94	1.84	16
8	Southern Company (Atlanta)	9.2	34	30	14,833	2.46	2.62	25
9	Public Service Electric & Gas (Newark)	8.3	39	42	10,299	1.83	2.00	45
10	General Public Utilities (New York)	8.0	41	45	10,424	1.84	1.97	43
11	Philadelphia Electric	11.9	16	21	12,180	2.80	2.66	22
12	Columbia Gas System (Wilmington)	10.4	29	29	11,957	2.95	2.79	17
13	Consumers Power (Jackson, Mich.)	8.4	38	37	11,176	1.88	1.95	40
14	Detroit Edison	7.1	47	35	16,013	1.22†	1.66	49
15	El Paso Natural Gas	9.3	28	28	6,231	1.80	1.73	14
16	Virginia Electric & Power (Richmond)	7.4	45	32	10,573	1.57	2.05	37
17	Texas Eastern Transmission (Houston)	14.0	7	8	4,750	2.70	2.40	2
18	Middle South Utilities (New York)	15.1	2	12	9,122	1.61	1.48	9
19	Pennzoil United (Houston)	14.1	4	2	9,442	2.16	2.02	1
20	Texas Utilities (Dallas)	11.4	17	6	8,212	3.33	3.03	28
21	American Natural Gas (New York)	7.7	44	18	8,703	3.38	3.29	26
22	Niagara Mohawk Power (Syracuse, N.Y.)	9.8	27	46	9,107	1.48	1.52	44
23	Northeast Utilities (Wethersfield, Conn.)	11.1	22	20	7,319	1.16	1.26	36
24	Florida Power & Light (Miami)	11.2	20	27	7,334	3.95	3.72	20
25	United Utilities (Shawnee Mission, Kan.)	10.7	23	27	24,129	1.15	1.32	15
26	Northern Natural Gas (Omaha)	10.5	24	9	6,063	1.92	2.00	26
27	Peoples Gas (Chicago)	13.3	10	33	7,876	4.15	4.21	19
28	Consolidated Natural Gas (New York)	13.0	12	33	6,627	3.58	3.26	8
29	Transcontinental Gas Pipe Line (Houston)	13.4	9	14	8,064	2.61	2.70	80
30	Northern States Power (Minneapolis)	9.5	32	43	2,113	1.78	1.70	3
31	Continental Telephone (St. Louis)	11.9	15	34	6,581	2.41	2.24	32
32	Allegheny Power System (New York)	14.5	3	22	16,600	1.40	1.28	—
33	Central & South West (Wilmington)	7.9	43	15	5,250	2.03	1.90	29
34	Pacific Lighting (Los Angeles)	7.9	43	3	5,608	2.85	2.66	13
35				47	9,100	2.03	2.01	46

Rank	Company	Net income as percent of equity			Employees ⁶		Earnings per share				Growth rate 1960-70 ⁷	Rank
		Per- cent	1970	1969	1970	1969	1970	1969				
36	Baltimore Gas & Electric	9.6	29	26	7,651	28	2.77	2.60	1.48	6.47	18	
37	Pennsylvania Power & Light (Allentown)	7.6	46	36	6,372	33	1.97	2.32	1.73	1.31	48	
38	New England Electric System (Westboro, Mass.)	10.0	26	31	7,968	26	1.98	1.96	1.35	3.90	34	
39	Panhandle Eastern Pipe Line (Houston)	16.5	1	1	3,695	45	3.14	2.91	1.49	7.74	7	
39	Potomac Electric Power (Washington, D.C.)	7.9	42	48	3,880	44	1.25	1.09	.96	2.67	42	
40	Long Island Lighting (Mineola)	9.6	31	25	5,515	40	1.95	1.94	1.09	5.99	24	
41	Ohio Edison (Akron)	12.3	14	16	5,787	37	1.84	1.92	1.07	5.57	27	
42	Wisconsin Electric Power (Milwaukee)	8.1	40	41	5,631	38	2.06	2.07	1.40	3.94	33	
43	Houston Lighting & Power	13.2	8	10	5,301	41	2.56	2.27	1.09	8.91	4	
44	Pacific Power & Light (Portland)	9.6	30	40	3,140	47	1.67	1.58	1.18	3.53	38	
45	Gulf States Utilities (Beaumont, Tex.)	11.3	19	23	3,004	48	1.49	1.38	.69	8.00	5	
46	Carolina Power & Light (Raleigh)	7.2	48	50	2,910	49	1.56	2.05	1.12	3.37	39	
47	Western Union (New York)	5.2	50	50	23,735	3	2.28	2.37	1.72	2.86	41	
48	Cleveland Electric Illuminating	14.2	6	11	4,869	42	3.02	2.92	1.49	7.32	10	
49	Illinois Power (Decatur)	14.3	5	4	3,444	46	2.89	2.67	1.46	7.07	11	
50	Total				1,237,454							

¹ Total assets employed in business, net of depreciation, Dec. 31, 1970. Assets of consolidated subsidiaries are included.

² Gross receipts from operations during calendar year 1970, including any nonutility revenues from manufacturing, transportation, etc.

³ That is, after taxes and after special items when any are shown on the income statement. A double dagger (‡) signifies a charge representing at least 10 percent of earnings shown.

⁴ That is, the sum of capital stock, surplus, and retained earnings as of Dec. 31, 1970. Common and preferred stocks of subsidiaries have been excluded.

⁵ Year-end total.

⁶ Earnings per share have been computed as described in footnote 7, page 172. A double dagger (‡) means that there was a charge representing at least 10 percent of earnings as shown.

⁷ That is, the average annual growth rate, compounded.

⁸ Figure is for South Penn Oil.

⁹ Figure is for Western Massachusetts Cos.

¹⁰ Not available.

¹¹ Not on lat year's list.

A STRUGGLE FOR CAPACITY

Insistent consumer demand provided the fifty largest utility companies with a hefty 8.9 percent gain in operating revenues last year. It also prompted them to make some monumental capital expenditures; the utilities increased their assets by 12.1 percent, the largest year-to-year gain since the list was first compiled fifteen years ago. American Telephone & Telegraph, which perennially dominates the list, made an especially frantic effort to keep its capacity within hailing distance of demand; in the process, it added a record \$5.7 billion to its assets, an amount greater than the total assets of the second-largest utility, New York's Consolidated Edison.

Operating costs continued to increase more sharply than revenues last year, in great part because of inflation and attempts to combat pollution. As a result, the utilities made only a meager 2.8 percent gain in net income, the second smallest advance in the past fifteen years. Ten of the utilities on the list, including American Telephone, suffered declines in net income; for American Telephone it was the first such decline since 1947. A few utilities dramatically increased their earnings, among them Union Electric, of St. Louis, whose net rose 25.8 percent, Potomac Electric Power, up 21.7 percent, and Southern California Edison, up 18.2 percent. All were helped by substantial rate hikes.

There was one newcomer to the list, Carolina Power & Light. The firm, which serves some rapidly growing industrial areas in both North and South Carolina, increased its assets by a whopping 23.1 percent last year and vaulted into forty-seventh place.

Senator HART. We have two additional witnesses for today and because of schedule problems we will hear the second witness before taking a 12:30, noon recess. And then we will take a recess.

And we will hear the testimony of Mr. Siegfried following the recess.

STATEMENT OF JEANETTE OSBORNE, ATLANTA, GA.

Senator HART. Our next witness is Jeanette Osborne of Atlanta, Ga. Mrs. Osborne.

Mrs. OSBORNE. Well, I do not really know how to begin, I have notes, but I will probably forget them, as I go along—

Senator HART. If you will pull that mike just a little closer, I think it would be easier for you.

Mrs. OSBORNE. We were a fine, happy, average family. We had just bought our new house in July of 1962. I had a good job with Crown Cork & Seal and my husband was with Atlanta Gas Light Co. and everything was just looking rosy, except for my young son who had asthma from birth and heart failure at the age of 6 months. We almost lost him.

But when we bought our home, he was doing better. Things looked much better.

On March 9, 1963, while at work, my husband came to my work and told me that our oldest son had been killed in an accident. Well, unless you have lost a member of your family, you cannot realize what a shock this was to me. It is unbelievable. And for quite a while I was in shock.

Before we had the child buried and back home, and trying to get to normal, an insurance adjuster came to me to settle—he was afraid of being sued. There were five other boys in the car. All the other parents were screaming, "Sue, sue, sue the insurance company." And I talked with the man and I explained to the man that I had no intentions of suing because the money that I could get from the loss of my child

could buy nothing I wanted. If it would buy my child back, I'd sue, but other than that, I did not want the money.

So the man handed me a check for \$3,000 and quickly had me sign the release papers.

I had another daughter named Carol who was the picture of health and had always been a real healthy child. In March 1965 she started having trouble with her hips and started limping, so I took her to doctors here and there.

She was in and out of hospitals many times and numerous trips to doctors' offices with no success. The doctors couldn't diagnose her illness. The X-ray showed nothing but her blood tests just kept coming back elevated. She got to the point where she could hardly walk.

It was neurosurgeons and bone specialists, every type of doctor one could name, and finally the doctors decided that she had arthritis. So they put her in traction and started treatment for arthritis.

With the cortisone injections, she did get better and she was able to come home, limping. Just for a few weeks though and then back to the hospital for more tests.

Eventually many other doctors were called in, we had an internal specialist that came in, and this time they did a biopsy instead of X-rays. This time it showed up that the child had Ewing sarcoma. This is one of the fastest types of bone cancer known.

The life span of anybody with Ewing sarcoma is 2 years. According to the child's diary, she lived out almost her entire 2 years.

She got to the point she could not walk. The cancer had traveled completely over her entire body. She had eight spots on her skull. She could not eat. The pressure on her neck was pressuring the esophagus, she could not swallow.

There were many transfusions. I had to leave my family at home each time she was hospitalized. I had two small children at the time. I had to stay at the hospital with the child because she needed a nurse around the clock and the insurance just did not provide for nursing care.

We did have two insurance policies but, again, you run into insurance problems. It seemed that as long as my insurance was in effect, my husband's insurance had a clause where it would pay nothing. I argued that fact with the insurance adjuster at the hospital.

It is a known fact that all over the world that the man is the head of the household but yet, in this insurance, it said because I had insurance, then his insurance would pay nothing until mine lapsed.

So, in 1965, we had two insurance policies in effect. Our part, after both insurances paid—which his did not pay anything, was \$892.05. This is according to income tax records which we filed.

The cancer was diagnosed in November of 1965. In 1966, our part, what we had to pay out of our pockets, was \$1,647.25. That is above expenses, over and above insurance payments, with two group policies in effect.

The child died March 9, 1966. During that time I had a friend, who called the Cancer Society and asked for help for us as I have no relatives in Atlanta. She was told since I had insurance the Cancer Society couldn't help us. I had to turn to our friends to look after both children. And I had to take a leave from my job and stay at the hospital. My bed, for the last 65 days of the child's life, was an outside

chaise lounge. The hospital tried to make me move it, but I had to sleep some to keep going. The child had to be looked after day and night and I could not afford a nurse around the clock. We could not afford a nurse anyhow.

I needed help with the small children at home. A friend of mine called the Cancer Society and asked for a nurse, a maid. Would they please provide just a maid for the children while my husband worked and they said that they didn't do that. They would provide transportation to and from the hospital for me. Well, I didn't need that. I had to stay at the hospital constantly. And that was all that the Cancer Society would do.

And as long as you have any insurance at all, anything, there is no help available through the Cancer Society, and so forth.

Then Lynn, our baby, was examined in November of 1968. She was hospitalized the first time for 34 days, I believe. Many, many transfusions and treatments for leukemia and she responded well.

She left the hospital and to see her on the street you really could not believe that there was a thing wrong with the child. She had to have weekly visits to the doctor's office for treatment and blood tests and so forth and medication, at least twice a week. The leukemia specialist, \$20 each trip; and she also had to see the pediatrician, whose was \$10 per visit. That's \$30 twice a week. And my husband's insurance would pay 80 percent.

Her medical bills were just completely unreal, and she was back in the hospital. For a year, she responded well, almost to the day. She went back in the hospital in November and was there almost until Christmastime.

This time she was getting weaker. More transfusions, more treatment. She finally appeared to improve. We got her home for Christmas and one of the treatments that they gave her—well, all the treatments for leukemia are potent poisons. This time, it was an intravenous treatment. A mistake was made while giving the child the treatment. The medication came out of the vein and seeped under the foot. The child almost lost her foot as a result. I don't think the doctor even realized, didn't even know what would happen. They were just waiting to see what would happen next. The child could not walk until January.

Then the next year it was just one visit after another to the hospital and treatment as an outpatient in hospitals. There were many doctors called in besides leukemia specialists. At one time she had nine transfusions in one visit to the hospital.

The last time that she was in the hospital, she didn't respond. There were various treatments. And, of course, I had to leave my family again, leave my job, which cut our salaries half in two, and stay constantly with the child. There was nothing else to do. We could not afford a nurse. Insurance did not take care of those things.

She was there 45 days and the doctor just said, "Well, that is all that can be done. That's it."

I have some figures here. Medical expenses during Carol's illness, which was our oldest daughter, 1965, after two group insurance policies paid, was \$892.05; 1966, \$1,647.25.

In Lynn's case, which was the baby with leukemia, medical expenses during the sickness of Lynn in 1969, \$432.90; in 1970, \$1,862.

From 1965 to 1970, the cost of a private room at the one particular hospital had tripled, but the benefits of my insurance had not increased at all.

I thought—the average person thinks, that they have good insurance. As a matter of fact, I thought we were well off insurancewise. I had insurance, my husband had insurance, but it took one visit to the hospital to learn what insurance you really do have. The policies have so many little clauses.

The average person, they go to the hospital and they stay, say, 10 days, and the hospital bill is fine, everything is paid off. All right, if you go to the hospital and stay 60 days, then you better have some money, or you are in trouble.

One time, while the baby was sick, she started convulsions at home and my husband wasn't there. Well, the only thing I could do was scream for a neighbor and jump in the car and take off for the hospital. We ran into the emergency room. My doctor had not arrived. I ran in, and by the time we got to the hospital the child was out completely unconscious. When I left home, I forgot—I panicked. I thought the child was dying—I suppose she was—and I did not even carry anything to keep her from chewing her tongue. She had chewed my fingers—I held my fingers in her mouth to keep her from chewing her tongue. My fingers were bleeding. I walked to the desk and explained that the child had leukemia, to get a house doctor quickly and the only response that I got was, "Do you have insurance? How will this bill be paid? Will you pay it cash?" And so forth.

Finally, I said, "Get me a doctor". I got ugly: I got rude. I said, "My child is dying. Will you please get a doctor. Here is my handbag. Go through it. Find what you need. Write out a check, if you need it. My husband will be here soon." They were more interested at the hospital with how their bill would be paid than my dying child.

There are so many mistakes. There are good people and bad in every walk of life, and we all make mistakes. None of us are perfect. But nobody realizes the fatal mistakes that are made.

I stood with my children and I have been scorned for that reason. I have stood over my baby and held her while they did bone marrow, while they did lung biopsies, and so forth. One time in particular, my doctor ordered a spinal injection. The house doctor came. One of the house doctors did it, and I am sure that he is a good man, he is a good doctor, but had I not been in that room with him, heaven knows what would have happened to that child. He stuck the child in the spine eight times. Her hair—she was dripping. She was just completely given out. Her heart was pounding. He was trying to hit the spinal cord, but he was not—he did not know. So I stopped him. I said, "No, no more. The child has had all she can stand." I said, "I realize it has to be done. I want it done. But she cannot stand any more." I said, "Now, we will get a doctor that can do it."

He said, "Well, your doctor ordered it." I said, "Sure, I understand." He said, "Well, it has to be done." I said, "I understand, but I think personally that we need another doctor to do this."

So I went to the phone and I called my leukemia specialist and explained. He said, "And I specially asked for one particular doctor that I do know and he is good in that field. He is not your pediatrician." He said, "You have to consult your pediatrician." So I did this, and

he said it was fine with him and he would rather that I did call the other doctor.

The doctor came in. He said, "Has this child ever been X-rayed in her spine?" I said, "No." He said, "She has a spinal (bifiter)," which is a crooked—I am sure you understand what I am trying to say. But he said that unless a doctor knows exactly what he is doing, and knows that this child has this condition, he could stick her in the spine all day and never hit the right spot.

And I have been scorned for standing over my children many times. "How can you stand it. You must not have a heart." But I could stand and watch them and help because I knew it was helping my children, and I knew that my children had better care if I was there.

The nurses are fine, but the hospitals are understaffed. The nurses are underpaid. They are overworked. Some of the doctors are good. But anybody that thinks they are well covered with insurance, they better sit down and check.

We don't consider ourselves poor people. We are average people. The money that I got from my son's death, the \$3,000, like I said before. I could not buy a thing with that money. It could not bring my child back. I could not find a thing that I wanted with the money, so I put it in a savings account. Had it not been for that savings, heaven knows what we would have done when our daughter got sick. We would have just been up the creek without a paddle.

Working men, and women try to carry their own weight in this world, and try not to ask for help. They want to carry their own weight. There is no help available for that person. But a man up on the street that can't find work, he might get some help. The rich man does not have to worry. It is the average citizen that needs help, they need it. I believe every human being in the world is entitled to health care as a matter of right, not wealth or charity.

I have had dealings with neurosurgeons, leukemia specialists, chest specialists, every type of doctor one can name. They are all expensive. A person's insurance just does not cover his fees. Even with two group insurance policies, it is just not enough. Possibly in a minor operation like appendicitis it might be fine.

Now, my particular insurance, I pay \$49.50 a month for group insurance. (I pay as it is negotiated for us through the union as part of our wages.) I have eye and dental care. Glasses cost \$115.00, the insurance paid \$25.00.

My husband had surgery on his gums for the simple reason that while our children were sick we could not afford to go to the dentist the way that we should go. We let ourselves go. He had to have surgery on his gums to save his teeth.

The bill for that was \$500. The insurance company paid \$136, and it was by force that they paid that. When I called my insurance company they said, "That is not covered under dental care." I said, "well, that's fine. If it is not covered under dental care, how about surgery. I should be covered under surgery." They said, "no, it is more dental work." In other words, they are arguing me that I had no coverage under surgery and no cover under dental care. I said, "all right," I said, "have the president of the company call me." And I said, "I will hash it out with him." So I did. And eventually, after a big knock-down-drag-out fight, he sent me a check for \$136 of a \$500 bill.

My son, the only child I have left, is still an asthmatic. The doctors say his heart is fine. He has never been able to be active in sports and things until last year. He has to have allergy shots every week. His medicine is expensive. He has to see an allergist for new medication in 3 months, which is expensive.

And all the time these other children were sick, I was having to leave this child. He had been pitched from neighbor to neighbor, anybody that would care for him, because I had to be in the hospital. I had to be with the child who needed me the most, which was the one in the hospital. All of this has had an effect on this child. He—I suppose he is one of the happiest little fellows in the world. Last year was the first time that he, ever in his life, was able to play baseball. And naturally I feel—I am overprotective, after losing three children you are overprotective, but I try not to be. I try not to let him know so, anyway.

His bills—we are still struggling. In other words, all of this, this sickness and trouble that we have had, even with two insurance policies in effect, had we not been people that were real—that would save—we were real conscious of our bills and we saved every dime that we could rake and scrape.

And we denied ourselves. The things that average people, the majority of people, would go out and buy, we would deny ourselves that. We feel this. We are afraid to be broke. We are afraid to spend.

I don't go out and look and on impulse just buy something. I go back home and I think and I figure and I wonder, "well, can I afford it." We deny ourselves so many things because we know we have this one child left and we don't know how long—we don't know what is going to happen. His heart has been bad one time before. It could happen again, I am sure. We want to be prepared. We don't want to have to beg for help.

I suppose, in these other cases, that we could have advertised in the paper and begged for help, but we don't want that, we did not want that. We wanted to carry our own weight. And had our insurance paid the way it should have, then all this would not have happened. But in a major medical sickness, any average person—in just one major medical sickness, and we have had two—the average person, it would take them 10 years to catch up. At least 10 years, with good hard work.

During the illness of the baby, who had leukemia, while she was at home and doing well, I had to go back to work. That's another thing that I was scorned for. I had to go back to work and try to save as much as possible because I knew that there would be another visit to the hospital, more expense, and we had to meet those bills.

Hospitals demand payments. Some hospitals, if you don't have any insurance at all, then you have got to have some cash to get in that hospital, I don't care how sick you are. They are not interested in how sick you are. They are interested in how much money you have got, how much insurance. So this is the situation. I don't care who it is. Any average working person that thinks that they have enough insurance, then they need to stop and figure and question this thing. Because there are so many little clauses in those insurance policies that will throw you off balance.

Insurance companies work on ignorance. People that take things for granted. You have got to sit down and read and question and

you have almost got to be a lawyer to really understand, or the hard way, the way I did.

Thank you.

Senator HART. Thank you very much, Mrs. Osborne. In view of the experiences that you had had, I think all of us are struck by the restraint that you did show in discussing your experiences.

And the unhappy truth I suppose is, that while we do not hear from very many who have had this experience, it is not as unusual or extraordinary as we tend to think.

Mrs. OSBORNE. No, I did not come here for sympathy because I have never felt sorry for myself. I have decided that God needed those children more than I did, for some reason. There are many people that have had just as many tragedies as I have. There are many people that have had more than I have. There are many people that are in worse shape than I was in. And therefore I did not come for sympathy, I came to try and explain to you that there are people in this country that try to carry their own weight and they try to carry enough insurance and so forth, but it is just not possible.

An average workingman just cannot buy enough insurance. If you buy the insurance, why, it is no good. Nine times out of ten, if you have more insurance policies, then they will not pay, they have clauses in them.

Senator HART. Well, you have made clear the consequences that follow from even single major medical sickness. Difficult as your own experience was, there was available the group coverage that eased the situation somewhat.

You made clear the need for all of us to understand before the illness and the submission of a claim exactly what our insurance does cover. And yet that is easier said than done, even if you are a lawyer, apparently.

And you have commented on experiences with hospital personnel with doctors. It describes in short an experience that we ought to be able to do very much better.

Mrs. OSBORNE. Well, most of the hospitals are understaffed and underpaid, and I am sure that the nurses do the best they can, but there is a limit to what anyone can do.

And when they are overlooked that much, they have a tendency to make mistakes, some could be fatal. So there is nothing to do except stay yourself and try and help.

Many mothers were not even as old as I was and could not stay. They had larger families at home. I know in one case in particular where a child had leukemia and his mother just could not stay. He was pitched in a ward, and many, many times I have gone back and checked his transfusions and so forth to see that his fluid was dripping right and so forth, because the nurses just did not have the time.

Where is all that money going? Nurses are not making it. I don't know. But I do know that insurance payments are way below the prices of hospital rooms, doctors, medicine and health care.

Senator HART. The frustration up here is—and I am sure it is shared by everyone in the room, whoever they are, whatever their role may be—is that we cannot take this noon recess with the silent conviction that we are going to fix all of the things that you described.

Mr. O'Leary.

Mr. O'LEARY. I have no questions.

Mr. CHUMBRIS. The only comment I have, Mr. Chairman, is that the Federal Government and Congress have passed so many laws that have helped in so many areas—hurricanes, floods and everything else—but they never have realized the importance of catastrophic insurance, which Congress is now considering. Such a law would help the people that may have this catastrophe by taking care of that problem. But the bill that is pending before Congress at this time does not meet Miss Fletcher's problem, as she testified to last month when she was here.

And as Senator Hart indicated, we do not know yet how that problem is going to be resolved, that type of problem that you had with your family. We have had three instances of witnesses coming before us, during the course of these hearings on high hospital costs and the hearings that we are now holding. It seems that this is one type of problem that somehow or another Government, industry, everybody else, must strive to work it out, because of the 200 million people in the United States, the number affected by it is very small in comparison to our total population.

But for that particular family, it is an unbearable situation to live with, especially when you feel as though you are helpless to resolve it.

Mrs. OSBORNE. Well, this is the way I feel. The richest country in the world. It is a crying shame that we cannot have the protection. I think it is a crying shame. As far as automobile insurance, well, you can replace that automobile. You can replace a house if it is blown away, but you cannot replace a life. You might have 10 children, but if one child out of that bunch dies, those other nine are not going to take its place. You just cannot replace a life. And if you have a member of your family that needs medical care, I don't care how poor you are, or how rich you are, somehow, somehow, you are going to get the best health care for that person. I personally would, and I feel like the average person would, and it is a crying shame that the average person cannot afford it. The richest place in the world.

Senator HART. Thank you, very much. The committee will recess and resume at 2 p.m.

(Whereupon, at 12:45 p.m., the meeting was adjourned to reconvene at 2 p.m.)

AFTERNOON SESSION

Senator HART. The committee will be in order.

This afternoon we are going to have the testimony from vice chairman of the board and chairman of the executive committee of the Metropolitan Life, Mr. Charles A. Siegfried.

Mr. Siegfried?

Mr. SIEGFRIED. Mr. Chairman, ladies and gentlemen, my name is Charles A. Siegfried. I am vice chairman of the board of Metropolitan Life Insurance Co. and chairman of its executive committee.

With me today are two of my Metropolitan colleagues, Mr. William S. Thomas, executive vice president, on my right, and Mr. Edwin B. Lancaster, senior vice president and chief actuary on my left.

Mr. Thomas heads our group insurance and pensions department, and Mr. Lancaster, prior to his current position, was senior vice president, in charge of home office operations for all individual insurance. He is a fellow of the Society of Actuaries and a past president of that organization.

I will try to present my statement in abbreviated form so that I will limit my—

Senator HART. We will order the full statement with accompanied documents printed in the record.

(The document follows. Testimony resumes on p. 921.)

STATEMENT OF CHARLES A. SIEGFRIED ON BEHALF OF METROPOLITAN LIFE INSURANCE CO., BEFORE THE SENATE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY—JUNE 6, 1972

My name is Charles A. Siegfried. I am Vice-Chairman of the Board and Chairman of the Executive Committee of Metropolitan Life Insurance Company. I was Chairman of the Health Insurance Association of America; I served on the most recent Advisory Committee on Social Security; and I am a member of the President's Committee on Health Education. During practically the whole of my business career, I have been involved with matters pertaining to health, medical care, and health insurance.

With me today are two of my Metropolitan colleagues, Mr. William S. Thomas, Executive Vice-President, and Mr. Edwin B. Lancaster, Senior Vice-President and Chief Actuary. Mr. Thomas heads our Group Insurance and Pensions Department. Mr. Lancaster, prior to his current position, was Senior Vice-President in charge of Home Office operations for all individual insurance. He is a Fellow of the Society of Actuaries and past president of that organization.

Metropolitan Life Insurance Company has a deep involvement in the business of health insurance, and medical expense insurance is a major part of this business. However, the interest of Metropolitan in matters pertaining to health and medical care long antedates its involvement in medical expense insurance. The company organized a Health and Welfare Department in 1909, and ever since then has been actively engaged in a variety of activities concerned with problems associated with disease and accidents and having an important bearing on the health and welfare of the people of the United States and Canada. Attached as Appendix I is a summary of some of the many contributions Metropolitan has made through its Health and Welfare Department.

Hence, while we have an important and extensive business interest in the subject under consideration, our interest is of a much broader and deeper nature. We have for many years been seeking good answers to the health and medical care questions which have been confronting the people of our country quite apart from any specific business interest.

Over the years, we have sought to be well informed on all lines of thought bearing on these matters, on all developments which might favorably influence the health and well-being of the American people. We have tried to keep in close touch with thought leaders and other persons working in these fields who had constructive suggestions for improvement. It has been an exceedingly active field. In this process of keeping informed, and in the experience developed in the administration of our business, we think we have gained much knowledge and many valuable insights. On the other hand, we readily acknowledge that health and medical care and the financing of medical care, and health education and related matters, comprise a subject of vast scope and complexity. We are pleased to observe the interest of your Subcommittee, and we are pleased to be able to share our views and experience with you.

HISTORICAL BACKGROUND

Discussion of issues relating to health insurance can be more meaningful if there is an understanding of how it has developed and of some of the major principles and influences which have been operating in this development. In this statement, we shall endeavor to condense what is really a very long and complex story, and thus shall, in effect, provide just a few highlights. However, we shall be glad to fill in as many more details as your Subcommittee may wish.

The early beginnings of health insurance date mainly from the early 1930's in a variety of moves to help individuals deal with the costs of hospital care and with the costs of surgery. At that time, these were the largest items of medical expense confronting most people, and having a means of prepaying such expenses or insuring against their occurrence had strong appeal. This also had appeal to hospitals and physicians who, in the absence of such a mechanism, shared the financial problems of their patients and their families. The

growing need for such a mechanism may also be attributed to a growing reliance on surgical procedures and on the utilization of hospitals. It is instructive to recognize that from the outset the problems we are considering stemmed from a mixture of developments related to science, medical technology and practice, changing patterns of social life and behavior, and changes in the economy.

Also noteworthy is the fact that important differences of viewpoint and outlook developed very early, and these have had significant influences on what followed. These relate to differences in the agencies and organizations created to provide protection. The Blue Cross-Blue Shield organizations, on the one hand, were provider-oriented and emphasized service benefits. Their concept was one of prepayment and emphasized first-dollar coverage.

Insurance companies, on the other hand, adopted concepts associated with risk-sharing and payment of specified dollar benefits upon the happening of certain contingencies. Generally speaking, insurance companies tried to move away from first-dollar coverage by utilizing deductibles and coinsurance and to emphasize coverage for the more severe cases rather than the more minor ones as measured by costs. Our view has always been that it was fortunate that there were these various, different approaches. We felt the field was so large and the problems so complex there was room for a variety of different approaches.

Over the years, intense competition has prevailed among the various plans and concepts. In the process, many different ideas have been tested. Partly because of this competition, partly because of growth in medical science, partly because of consumer desires and pressures, and partly because of inflation, there has been a vast growth in health insurance and prepayment plans. Surveys indicate that over 170 million people have some form of coverage. We think this has been commendable, instructive, and that it has fostered sound growth and development.

There are still strongly held differences of view as to what are the most desirable characteristics of medical expense plans. These differences exist among consumers, among providers of services, and among insurance companies and other institutions providing coverage. Considering the magnitude of the issues, this is a healthy situation. We are still in the learning process.

Many people favor comprehensive coverage with emphasis on adequate benefits for the more severe cases. However, the variety of medical services is great, and many practical choices and options and alternatives are available as consumers consider what best fits their needs and circumstances.

For example, some people prefer the convenience of coverage that pays all or nearly all of the costs in even the least severe cases and forego coverage or take more limited coverage for the more severe cases. Some may prefer more coverage for hospital confinement cases and forego coverage of expenses for certain items such as drugs, home nursing care or physicians' visits outside a hospital. These are just brief indications of how variations in plans came about.

Certain items of medical expense have proved to be difficult to prepay or insure on a completely satisfactory basis. Included in these are treatment of mental illness, dental work, private duty nursing, care that borders on custodial care, particularly of the elderly, etc. These are problem areas because they contribute to make the cost of a plan unattractive, because the existence of the plan seems to encourage excessive utilization—at least as measured by utilization in the absence of coverage—and because of a variety of technical and administrative problems.

Still another aspect on which views differ has to do with the basis of dealing with individuals and groups having different risk characteristics and, consequently, presenting different levels of cost. Some people have favored "community rating," i.e., all persons in the same community pay the same rate. Others favor a principle of classification of risks, and, consequently, a basis of premiums which varies the premium according to the class of the risk. Under this approach, people presenting the same risk characteristics pay the same premiums.

In mutual insurance operations, a further principle applies, that is, if actual experience reveals that the premium initially charged is higher than the cost actually realized, then the excess is returnable as a dividend. Generally speaking, the insurance buyer desires to have his costs commensurate with his risk. This requires that care be exercised to evaluate and classify risks in accordance with appropriate underwriting procedures. This process has a collateral advantage of providing an incentive to individuals and groups to do those things which will contribute to improve their risk characteristics. In many cases, attention to sound underwriting has resulted in favorable cost experience, which in turn

made possible the purchase of a broader form of coverage than was taken out initially. The process thus has operated to extend the scope of coverage and pave the way for advances that might not otherwise have occurred.

During the last two decades or so—as medical expense insurance has been advancing—not only have consumers had a highly influential voice in the construction of plans, but insurance companies have diligently sought to keep informed on all aspects of the activities and thinking of the providers.

DIFFERENCES BETWEEN INDIVIDUAL HEALTH INSURANCE AND GROUP HEALTH INSURANCE

A discussion of health insurance requires also an understanding of the different characteristics of individual insurance and group. As the name implies, individual insurance refers to policies covering a single individual or an individual and his family. Group insurance is insurance covering a number of persons, usually the employees of an employer or the members of a union or an association, etc.

The group approach involves certain economies that favorably affect costs. For example, premiums are paid on a bulk basis, generally less selling effort is required, less underwriting effort is required and, particularly on employer-employee group plans, the employer performs certain administrative functions that must be performed by the insurance company under an individual policy.

There is much unjustifiable criticism of individual health insurance because the administrative costs appear high when expressed as a percentage of the premiums, as compared with the correspondence percentages under group policies. Usually these comparisons are made with large group policies where the advantages of bulk administration are relatively more significant. As the size of the group diminishes, the difference in cost, of course, narrows.

An important cost of any plan is the cost associated with establishing it in the first instance. This includes the costs of the selling activities as well as the underwriting costs, issuance of the policy, establishing the basic records, etc. Over the years, these costs have a diminishing impact on total costs. However much of the individual medical expense insurance is relatively new, and hence the initial costs are still an important factor.

Discussions of the cost of individual insurance frequently seem to ignore the unusual factors that have been experienced which unavoidably contribute to higher costs for this type of insurance. Among these are (1) the changing consumer views which lead to a desire to change policies relatively frequently; and (2) the increases in basic costs because of increases in the utilization of medical services as well as increases in the level of cost of such services.

Metropolitan's views as to whether or not commercial accident and health insurance companies are returning a sufficient amount of the (a) individual accident and health insurance, and (b) group accident and health insurance premium dollar in benefits to consumers.

A prime objective of our business is to make insurance available on a basis which is attractive and satisfactory to our customers and of acceptable costs.

The cost of insurance is the composite of the cost of the benefits that are payable plus the cost of administration plus the cost of taxes. As a mutual company, we do not produce a profit for stockholders or any other persons.

The cost of administration must provide for such items of expenses as (1) the cost of sales and underwriting, and placing the plan in effect, including the issuance of policy forms and the establishment of basic records; (2) the cost of collection of premiums from time to time; (3) the cost of payment of claims; (4) the cost of research and analytical studies; (5) the cost of risk taking, i.e., the charge to cover losses where the experience is unexpectedly unfavorable, and the costs of other unforeseen contingencies.

Information has been provided to your subcommittee showing the level of these costs for a variety of different types of plans.

The forces of competition and our business objectives exert a powerful force compelling us to keep costs as low as compatible with our obligations for proper service and maintenance of solvency. The facts of life are that medical expense insurance has been an exceedingly difficult business from a cost viewpoint because almost all factors in recent years have had adverse influences cost-wise—the evolving character of the business reflecting as it has rapid changes in medical practices and consumer desires, the inflationary conditions of our economy, changing patterns of consumer utilization of medical services leading to a stead-

ily increasing volume of utilization, and the ever-expanding scope of the medical expenses covered.

We believe our level of expenses is explainable, reasonable, and justifiable, but naturally we also believe they warrant continuing scrutiny. We can assure you that this scrutiny is searching, detailed, continuing, and productive. It involves not only the efforts of our own people, but our customers are demanding and we respond to their desires for accountability in many different and productive ways. While some feel costs are already high, there is evidence that somewhat higher costs might well be warranted to support additional statistical and research activities. Also, attention is called to the fact that deficits have been incurred in a variety of sectors of our medical expense business indicating that higher charges may be needed. This is mentioned, in part, to dispel the impression some people seem to have that medical expense insurance has been a business that is profitable or that it helps support other lines of insurance.

We do not claim that Metropolitan is unique in seeking ways to reduce the cost of medical expense insurance, but we can assure you that cost control is a major matter of concern. In the competitive environment in which we operate, it must be. It does involve a complex interplay of somewhat conflicting forces. Balance must be determined between attention to claim costs and the costs of doing those things that can reduce claim costs. Medical expense insurance is a service business, and good balance must be found between the quality of acceptable service and acceptable costs. We think we have been finding these acceptable balances, and we think our customers are being satisfied. It is, of course, a never-ending process.

What has Metropolitan Done to Control the Cost of Medical Care of Persons Insured Under Metropolitan Contracts?

In the beginning, it appeared appropriate that an insurance company should be careful not to inject itself improperly into the many decisions related to the need for medical care, to choices among various kinds of services, etc. It was felt these were matters for the professionals and for the consumers. This attitude seemed appropriate, partly because in most matters of this kind there seemed to be no clear-cut right answers, and it was questionable whether the knowledge of insurance personnel and their ability to form sound judgments and decisions would be sufficiently more reliable than the parties directly involved to warrant any attempt at intervention. These matters involve the selection of physicians and hospitals, whether to seek treatment in a hospital or elsewhere, whether to seek a longer or shorter period of hospital confinement, etc., etc.

As our experience increased, we have expanded our activities, seeking to ascertain a helpful role working with consumers (our insureds) and the providers of services.

At a very early stage in the development of medical expense insurance, Metropolitan recognized that the design of the insurance could influence utilization of medical services and, consequently, costs of the insurance and the total costs of medical care. Because of concern on this account, we favored insurance which did not operate to influence improperly the choice of medical services selected. In particular, we designed coverage that would not require hospitalization, with its attendant costs, to be reimbursed for services that could be provided outside a hospital. This led to our early development and endorsement of comprehensive insurance. We believe we were the first major underwriter of comprehensive insurance. We were among the first to underwrite major medical insurance, emphasizing coverage for the severe cases and utilizing deductibles and coinsurance to make the insurance more effective for the more severe cases.

There is attached as Appendix II a statement describing in more detail Metropolitan's activities aimed at controlling the costs of medical expense insurance and making coverage more effective. They have been considerable. Our experience gives us confidence that we have acted responsibly. We have solid accomplishments, we have advanced understanding, and we have laid a basis for improvements in the period ahead. Very briefly, this record encompasses the development of plans of great effectiveness, a broad variety of moves to accommodate to the views and desires of many different types of consumers, a great amount of attention to the views and problems of providers of services, and a great deal of effort to reduce paper work, to promote efficiency in administration, to encourage good health and safety behavior and, overall, to work toward more effective measures for dealing with health and medical care problems. We in Metropolitan think we have an enviable record.

METROPOLITAN'S VIEW AS TO DESIRABLE CHANGES IN THE PERIOD AHEAD

We think the record of growth and development of medical expense insurance is a record of high achievement. This reflects commendably not only on insurers, but on the segments of the public which have sought more and better plans, and on the widespread cooperation of the providers of medical care.

We are, nevertheless, mindful that as a nation we have a variety of vexatious health and medical care problems. We have worked with our industry colleagues in studying these matters and trying to find ways and means for effecting improvements. Our thoughts are contained in a broad-scale program called "Program for Healthcare in the 1970's." This is basically the same as the program contained in H.R. 4349 sponsored by Congressman Burleson and others in the House, and in S. 1490 sponsored by Senator McIntyre and others in the Senate.

This program undertakes to deal with the major issues currently affecting the health care scene: the problems of the poor, the near-poor, the uninsurables, catastrophic cases, etc. On the other hand, it endeavors to be realistic—it does not purport to be a panacea to resolve every conceivable issue that affects the incredibly complex total situation. We think it is the right program for this time. We think it would be a great step forward and would move to a position from which further advances can be made at some time in the future, if they are so indicated. It builds on current strengths and does not wipe away the many aspects of the current situation which are strong and which are functioning in a creditable fashion.

SHOULD ACCIDENT AND HEALTH INSURANCE POLICIES BE STANDARDIZED BY REGULATION?

The apparent simplicity and efficiency of standardization has appeal. However, there are many facets to health insurance which involve questions on which there are widely differing views. It would be exceedingly difficult to achieve "standardization" except arbitrarily and at substantial risk that the standardized form did not represent really the best answer. Standardization operates to make innovation, experimentation, and change more difficult, and yet at this stage of the development we do not have final answers and need the opportunity to learn through variation to improve.

The "Program for Healthcare in the 1970's"—by establishing a pattern of minimum benefits for plans entitled to the maximum allowable deduction for tax purposes—moves as far toward a greater degree of uniformity as seems desirable at this stage.

SHOULD ACCIDENT AND HEALTH RATES BE REGULATED?

Currently, there is already an extensive degree of rules and regulations concerning various aspects of health insurance rates.

The cost of health insurance is largely determined by the cost of the medical care services covered and by the rates of utilization of covered services. Regulation can be injected into the picture in a variety of ways, and there is little doubt it would alter costs and practices and behavior in a variety of ways. It is more difficult to be sure that moves toward more regulation would really be advantageous to the great mass of people. There are still too many variables and there are still too many unknowns to give us confidence that apparent short-range efforts to reduce costs will result in the most desirable situation overall.

Here, again, we believe the approach of the "Program for Healthcare in the 1970's" is most likely to provide information and experience for which longer range moves can be considered.

SUMMARY

1. Health, medical care, and the matter of medical expense insurance involves a broad and complex mixture of human, technological, and business problems.
2. There are many different views as to how these matters should be dealt with in the balanced best interests of consumers, providers, those paying the costs, and the public at large.
3. Substantial and continuing progress has characterized the many developments that have occurred in a relatively short span of years.
4. Metropolitan has been a leader in these developments—in developing effective plans of insurance, in engaging in a great variety of activities aimed at improving health and safety and the operation of insurance against medical

care costs, and in endeavoring to make insurance available at fair and appropriate costs.

5. Reducing the cost of medical expense insurance involves the judicious utilization of numerous potentials: health education, improvement in the organization and use of medical care facilities and personnel, cooperation among the numerous groups working in the field, improvement in the handling of administrative actions. Much also depends on the general economic, political, and business climate in which insurance is permitted to operate.

6. Metropolitan believes that the public interest would be well served if Congress enacted the measures contained in H.R. 4349 and S. 1490. Highly significant is the fact that these measures are comprehensive and deal constructively with the major matters of current concern, and they are aimed at building on existing strengths.

APPENDIX I

METROPOLITAN'S HEALTH AND WELFARE PROGRAM 1909-1972

Today, American business is actively engaged in demonstrating its social responsibility. Job training for the disadvantaged, capital investments in developing industries in slum areas, and control or prevention of environmental pollution are some examples. For Metropolitan, these programs fit readily into a long-established policy which can be dated back to 1909. At that time, we announced to the world that "Insurance, not merely as a business proposition but as a social program will be the future policy of the Company."

The factors which led to this innovative decision have been amply described by Marquis Jams¹ and Dr. Louis Dublin² in their histories of the Company.

In those early years of the century, the causes of many prevalent communicable diseases—tuberculosis, pneumonia, infectious diseases of childhood—were beginning to be discovered. Communities and states were creating public health departments to apply preventive measures, such as environmental sanitation, infant care, case finding and immunization. Many of our policyholders were immigrants who lived under wretched housing conditions similar to those found in ghetto areas today. They knew little about protecting or improving their health, even when they had the means to do so. In 1909, the life expectancy of our Industrial policyholders was lower than that of the nation's population as a whole. These conditions influenced the Company's policy decision and led to the establishment of the Welfare (later Health and Welfare) Division with the following objectives:

1. Through education, to prevent unnecessary sickness and premature death.
2. To encourage Metropolitan Agents visiting the homes of policyholders weekly to become a valuable body of health messengers.
3. To extend cooperation to health officials and welfare organizations in health promotion.
4. To encourage constructive health legislation and adequate appropriations for health work locally and nationally.
5. By demonstration, surveys, and research, to open up new avenues of disease prevention and to confirm and apply in practical ways discoveries in preventive medicine.

Today, these goals which stress prevention have special pertinence.

HEALTH EDUCATION

The cornerstone of this program has been health education. Tuberculosis was the most feared of all diseases at the time the Company started its new program. By the summer of 1909, an illustrated pamphlet entitled a War Upon Consumption had been printed. The contents gave advice on the prevention of the disease not only in English, but in Swedish, Polish, French, German, Italian, and other languages used by major American immigrant groups, and the Company's 10,000 Agents took an active part in distributing the pamphlet. In fulfillment of the second goal, this involvement of the Company's Agents in the program was a unique community service. Their "health messenger" role provided

¹ The Metropolitan Life—A Study in Business Growth, New York, 1947.

² A Family of Thirty Million, New York, 1943.

health information to families cut off from any other source of authentic health information.

In the years that followed the publication of *A War Upon Consumption*, one pamphlet after another appeared to spread information about the most prevalent diseases of the times. When new health discoveries were made, Metropolitan pamphlets were issued to tell the public about them. Our health and safety pamphlets have been used by public and private health agencies in numerous disease and accident prevention campaigns. Specific materials have been prepared to meet the particular needs of school children, classroom teachers, and school administrators. Outstanding among these are the classic Health Heroes Series, biographies of famous men and women who have contributed to science and public health—Pasteur, Curie, Reed, Nightingale.

The Company has distributed nearly two billion pamphlets since 1909. In 1971, more than 12 million pieces were distributed. Most of the 90,900 mail inquiries we receive annually are for booklets on almost every conceivable health subject.

The Metropolitan pioneered in health education via radio and has produced many motion pictures, filmstrips, exhibits, and displays over the years. Health and safety exhibits and special display materials are shown at meetings of medical, educational, and health organizations. Accident prevention, weight control and physical fitness, mental health, and child care are some of the past and current subjects of films. Our films reach a substantial audience—community group showing and commercial theaters and television. Last year, we had some 28,000 showings to audiences totaling more than five million persons.

Our health education materials are accepted as public service broadcasting on television and radio.

Volunteer blood donations, community ambulance services and the vital role they play in emergency medical care and transportation, the purposes and benefits of good day care centers, and the importance of adequate nutrition are among subjects featured currently in our television and radio one-minute spots. Estimated audiences for each spot, range, depending on the subject matter, from 29 million to more than 57 million persons.

For years, the Company's advertising has been devoted to health and safety subjects.

One example of health advertising was the Rubella (German measles) vaccination ad run in national magazines in 1970 and 1971. This ad supported a nationwide campaign to immunize all children between one year of age and puberty against German measles. Although this is a relatively harmless disease of children, women who are infected in the early months of pregnancy are at high risk of delivering a dead or a defective child. During an epidemic in 1964, about 20,000 children were born with serious impairment of heart, hearing or sight. The Federal Department of Health, Education, and Welfare reprinted the ad at their own expense for distribution to state and municipal health agencies.

New ads in 1971 have drawn and continue to draw unusually large responses from the public. One was entitled "A Junkie's Parents Shouldn't Be The Last To Know" and offered To Parents/About Drugs. Another, "Scott Isn't Stupid. But It Took A Smart Teacher To Recognize It." highlighted children's learning disabilities and offered our film, *Looking at Children and its accompanying publications*. Other ads in 1971 dealt with the Company's historic interest in disease prevention, with specific attention to diphtheria, tuberculosis and venereal disease.

The Company has won the *Saturday Review* top award for "distinguished advertising in the public interest" 13 times in the past 14 years. In 1971, Metropolitan won an additional award in the corporate campaign category.

HEALTH AND WELFARE TODAY

Prevention of illness, disability and accidents through knowledge and appropriate action was a cardinal objective in the founding of the Health and Welfare program and has been consistently pursued ever since. It assumes increased significance in the present era of rising expectations for medical care, health manpower shortages, and skyrocketing hospital and medical costs.

Today, the emphasis on consumer education and protection gives added impetus to programs that call attention to effective health and safety practices. Now perhaps more than ever before the individual must learn how to use the resources of modern medical science effectively and efficiently. He must be helped

to acquire a greater sense of personal responsibility for his health and to change many of his living habits in order to enhance his chances for a long and healthy life.

Our Company thus is in the vanguard of this new emphasis on health education. Today, there are seven important subjects which occupy our educational efforts.

1. Healthy environment

Currently, there is intense public interest in cleaning up the environment, and many businesses are attempting to make a positive contribution. Metropolitan is not a newcomer in this field. Five years ago, Health and Welfare Division produced two informational pamphlets—one on air pollution and the other on water pollution. These have been mainly used by schools and community groups. However, it was thought that the Company might be more active in other meaningful and helpful ways.

Thus, last October, the Department of Urban Affairs was reorganized to become the Department of Urban and Environmental Affairs and, since then, has been examining the problem jointly with Health and Welfare to determine what Metropolitan can do in the environmental field. To this end, Health and Welfare Division sponsored in December 1970 a conference of environmental specialists from universities, government and industry. While no specific courses of action were recommended, there was a consensus that the public needs a great deal of information about the complexities of environmental problems in order to understand the social, economic and health "trade-offs" inherent in the solutions to these problems. As a result, Health and Welfare is now developing a program that will be suitable for introduction into the curricula of secondary schools to develop a deepening awareness of the complexity and personal significance of environmental problems, with emphasis on the multiple factors involved in decision-making and the possible consequences of choices.

2. Drug abuse

The misuse of drugs, including narcotics, formerly considered a problem of the ghetto, has spread into all strata of society and is particularly acute among youth in secondary schools and colleges. The response to the Company's Speed Kills ad in 1970 clearly indicated that the public expects Metropolitan to assume a leadership position in the campaign against drug abuse. Further, many of the Company's representatives are being asked for materials and help in fighting the drug problem.

A general information booklet, *To Parents About Drugs*, directed to parents, teachers, clergymen, personnel supervisors and others in a counseling capacity, was released in October 1970 and 1.8 million copies have been distributed. A companion pamphlet, *To Young Teens on Druggism*, is being distributed to secondary schools for classroom use. Nearly one million copies have been distributed since September 1971. The emphasis of these materials is on prevention.

Employers, on the other hand, have to face the problem of drug abuse among employees. To respond to this, the Company in December 1970 co-sponsored with the American Social Health Association a conference of medical directors of large corporations in the New York City area. The proceedings, which reveal many valuable approaches to the problem as derived from actual experience, have been published under the title *Drug Abuse in Industry*.

3. Health observation of school children

A project completed by the Division in 1968 was a 24-minute color film *Looking at Children* which illustrates clues to health problems of school-age children. Conditions shown and discussed range from common infectious diseases to perceptual problems and chronic illness.

Looking at Children was produced under the direction of the professional staff of the Health and Welfare Division with the assistance of New York Hospital-Cornell Medical Center and the Ossining, New York public schools. All health conditions shown are real. No actors have been used.

The film is intended to help teachers, nurses, health aides, parents and others concerned with children to understand the health problems of children, be more alert to early signs of illness and defects, and improve their own skills in observing children. It should help to strengthen communications among parents, teachers and health personnel. It is supported with two supplementary reference booklets—one for teachers entitled, *Looking for Health* and another for parents, *Watching Your Child's Health*.

Looking at Children has special significance today when the shortage of physicians and other health professionals has led to increasingly more effective use of allied health workers. The film and its supplementary printed materials replace the Metropolitan filmstrip, *Teacher Observations of School Children* and the booklet, *What Teachers See*, which have been useful guides to educators for more than a quarter of a century. The Company's concern with health services for children dates back to the early 1930's. At that time the Company financed a study of causes for success and failure in detecting and correcting health problems discovered through medical checkups in the New York City public schools. The findings, which were of nationwide interest, led to the Astoria School Health Study in New York City, also supported by the Company. Among the effective practices demonstrated here was that the classroom teacher proved to be the key person in the detection of childhood health problems.

Looking at Children is now widely used not only in schools but also by colleges of education. A French-language version of the film has been produced for use in Canada. Looking at Children received *The Chris Award* for excellence in production at the Columbus, Ohio, Film Festival, and was a runner-up in the American Film Festival. Promotion in the Company's 1971 ad campaign on TV and in magazines has brought an overwhelming response.

4. *Day care*

Another problem of industry is that of freeing mothers from the responsibility of full-time care of small children in order that these women may be gainfully employed. Day care centers provide an answer but not a simple one. The health and education of the child must be provided for. Children between six months and six years of age are in a critical period of development and day care centers must have optimum facilities to promote healthy growth and the learning skills and cognitive abilities which the child will use the rest of his life. The Health and Welfare Division and the Department of Urban Affairs have been studying for the last four years the day care situation and have accumulated considerable knowledge on the subject. One result is a Health and Welfare publication, *Industry's Share in Day Care*, which contains essential information needed by any employer contemplating the establishment or support of a day care center. The publication is being distributed to executives of key Metropolitan Group-insured companies and other carefully selected audiences.

5. *Weight control and physical fitness*

A Song of Arthur, our current weight control film, is a 21-minute sound and color production and is the first musical health education film. It marks a milestone in our continuing program to accentuate the need for proper nutrition, diet, and exercise in order to live a longer, healthier life. The film and its discussion guide are available to community organizations, professional associations, service clubs, health agencies, high school and college groups, and others professionally and personally concerned with the subjects of fitness and health.

A Song of Arthur was awarded a gold medal at the International Film and TV Festival of New York, where it placed first in the category of health and nutrition. The entertainment aspect of the film makes it appropriate for commercial theaters and television showings. Bookings for the film have been very heavy. More than 18 million people have seen it since it was introduced in 1967, three million in 1971. This number includes TV viewers.

6. *Accident prevention*

As accidents have become a major cause of death and disability, trauma prevention, the promotion of safety, and the improvement of emergency medical services have been given special attention by Metropolitan Life. In cooperation with the American College of Surgeons, the American Medical Association, the American Academy of Pediatrics, the National Safety Council, and the U.S. Public Health Service, we have been endeavoring to stimulate communities and their leaders to review problems and needs in proper handling of medical emergencies. Planning to prevent emergencies and avoiding panic through knowing what to do when an emergency occurs are the two guiding principles of our action program.

For use in the Medical Emergency Information program, Health and Welfare developed a packet containing a selection of our publications that offer suggestions for planning to prevent emergencies and telling what to do if an emergency occurs. These are tailored to individual community resources and needs. A listing is also provided showing local emergency and health resources with their location,

telephone numbers and other relevant details. This information is obtained with the cooperation of the local medical society and other community services. Gathering it has the incidental advantage of revealing gaps in community emergency services that may be closed by the efforts of concerned citizens.

The Medical Emergency Information program was introduced first in the rapidly-growing Seattle area in 1967. To date, the program has reached tens of thousands of homes in all sections of the U.S.

Metropolitan has been associated with the development and promotion of poison control centers in the U.S. since 1955, when one of the Company's Medical Directors (now Vice-President and Chief Medical Director) serving as Chairman of the Committee on Accident Prevention of the American Academy of Pediatrics, was instrumental in establishing the first one in Chicago. In this capacity (and later as President of the Academy), he helped to establish the National Clearinghouse for Poison Control Centers in the Department of Health, Education and Welfare. He also led the fight to set the first standard for paint to minimize the lead poison hazard to children and contributed to many other child accident prevention programs.

The Company in 1960 established the first award for outstanding research on accident prevention. This was the first time that such recognition was given to research effort in this field. Administered by the National Safety Council, the award's purpose is to encourage investigation of safety problems and to evaluate on-going programs. The Company has contributed \$55,000 since the program was established.

7. Medical research

Our health education efforts have been solidly based on scientific research, some of which has been conducted by the medical staff of Metropolitan Life (partial bibliography attached). For example, the detection of coronary heart disease in its asymptomatic stage is one of the most important problems in medicine. Pioneer work in this field was done by one of the Metropolitan's Medical Directors who developed and standardized new procedures which provide more significant criteria for the interpretation of electrocardiographic changes associated with exercise. These criteria have been validated by a series of follow-up studies made in the Metropolitan's Statistical Bureau, and are now being widely used by clinicians and cardiologists.

Metropolitan was among the first health agencies to apply automated blood chemistry analysis to the periodic health examinations given to its employees. The primary aim in using this for a healthy population was to determine whether the biochemical profiles would facilitate early diagnosis, treatment and prevention of illness. Secondary objectives were to evaluate the usefulness of biochemical profiles in underwriting and to gain experience in bioengineering technology. Three reports on our experience appear in the *Statistical Bulletins* for December 1969, January 1971 and September 1971.

The Company has published the monthly *Statistical Bulletin* of informative data growing out of its mortality and morbidity experience since 1920. This periodical is distributed on request throughout the world and is extensively cited in scholarly research and the public press. Particular attention is given to the presentation of facts which would provide a solid basis for life conservation programs. There is also an effort made to indicate what yet remains to be done in the prevention of sickness, premature death, and accidental injury and to suggest fields for further research.

This brief and incomplete review of Metropolitan Life programs for consumer health education, medical research, accident prevention, and related public health objectives illustrates the Company's long-standing commitment to efforts to improve the health and well-being of the American people.

We believe that the programs we have described set the Company apart from any other insurance company. We believe that the need to demonstrate social responsibility is one of the major challenges which business faces in the future.

FINANCIAL CONTRIBUTIONS TO PUBLIC HEALTH

While the Company's contributions of funds to other organizations for health programs has been modest compared to such Foundations as Rockefeller or Ford, nevertheless, some grants have resulted in significant advances in public health. In 1915, the Company asked: "Is it possible for a typical American community to prove to the world that a large proportion of the sickness and deaths from tuberculosis is preventable?" The National Tuberculosis Association was asked

to investigate this possibility, and the Company offered financial support for the project in the community of Framingham, Massachusetts, which then numbered 17,000 persons.

The Framingham Demonstration proved that by putting to use the knowledge available at that time of how to diagnose, prevent, and treat tuberculosis, a community could control this deadly disease. During the seven-year program, tuberculosis deaths per 100,000 of population dropped from an earlier average of 121 to 38.2 in 1923! Many other towns and cities in this country and throughout the world successfully followed this example. Today, textbooks still point to the Framingham Demonstration as a model public health achievement.

The Company also contributed to the fight against influenza. The flu epidemic of 1918-1919 took the lives of 83,000 Metropolitan policyholders, far more than the American death toll in World War I. In 1919, having found the epidemic costly in lives and claims, the Company organized an Influenza-Pneumonia Commission composed of specialists in those diseases under the chairmanship of Dr. Milton J. Rosenau of Harvard. For 25 years this Commission financed fruitful studies of the causes and effective treatment of respiratory diseases. More than \$586,000 was spent by the Commission in this period of time on research projects. One project which improved the treatment of pneumonia achieved a reduction in our pneumonia death claims in one year great enough to offset the entire sum spent on the Influenza-Pneumonia Commission.

In 1945, the Company took the lead in establishing the Life Insurance Medical Research Fund. This Fund furnished financial assistance to educate scientists and provided grants in aid for medical research. The money was derived from contributions totaling about \$1.5 million annually from some 150 Life insurance companies. Metropolitan's contribution was \$150,000 annually. In 1970, it was decided that the Fund should be inactivated because there was a greater need for financial support of experiments in delivery of health care to improve quality, obtain better distribution and restrain rising costs. The collaborating companies believed they could respond to this need by direct contributions, and a central fund was no longer needed. Hence, the Fund will be phased out by 1975. During the 25 years of existence, it dispensed about \$25 million to assist medical research and education.

Metropolitan has contributed \$100,000 annually since 1968 to Washington University to support a demonstration in the delivery of medical care. This consists of a five-year study of the experience of an ambulatory group practice unit at the Washington University-Barnes Hospital Medical School. This program is probably the first in the nation to provide a well-designed and controlled research study of the effect of ambulatory and preventive care on the rate of hospitalization by enrollees in a prepaid service program. This will be compared with families receiving care from traditional sources.

Data from the first 12 months of service have recently become available. The sample group of some 310 families, totaling about 1,200 individuals, includes a number of employees of Metropolitan Life Insurance Company in the St. Louis area. A control group consisting of an equal number of carefully matched families which continued to secure medical care as they have in the past, will provide comparative data. Studies from this program should clarify the relationship of a full spectrum of ambulatory health services as the influence the utilization of in-hospital days. Insufficient time has elapsed to demonstrate any actual cost savings. However, as we had anticipated, there is strong evidence that programs providing ambulatory care, especially embodying preventive health features, tend to utilize in-hospital service to an appreciably lower degree. This reduction in hospital admissions has been particularly noticeable among children.

ARTICLES PUBLISHED BY METROPOLITAN PHYSICIANS AND ACTUARIES

Accidents

Wheatley, G.M. The physician and accident prevention. *ALIMDA*, 1953, p. 84

Wheatley, G.M. Accidents and school children. *Pediat Clin N Amer* 12: 941 November 1965

Wheatley, G.M. Relationship of home environment to accidents. *Arch Environ Health* 13:489, October 1966

Diabetes

Entmacher, P.S., Root, H.F., Marks, H.H. Longevity of diabetic patients in recent years. *Diabetes* 13:373, July-August 1964

Entmacher, P.S. Prognosis in diabetes. Cooperation Internationale pour les Assurances sur la Vie des Risques Aggraves (COINTRA). 11th Conference Internationale, Rome, Italy 1:263, September 30–October 4, 1969

Heart disease

Robb, G.P., Marks, H.H. Evaluation of type and degree of change in post-exercise electrocardiogram in detecting coronary artery disease. *Proc Soc Exp Biol Med* 103:450, 1960

Robb, G.P., Marks, H.H. Latent coronary artery disease. Determination of its presence and severity by the exercise electrocardiogram. *Amer J Cardiol* 13:603, May 1964

Robb, G.P., Marks, H.H. Prognosis in coronary heart disease. *Med. Sec. ALC* 1964, p. 68.

Robb, G.P., Marks, H.H. Postexercise electrocardiogram in arteriosclerotic heart disease. Its value in diagnosis and prognosis. *JAMA* 200:918, June 12, 1967

High blood pressure

Lew, E.A. Some implications of the Build and Blood Pressure Study. 1959. HOLUA Meeting, Boston, May 10, 1960

Lew, E.A. Build, Blood Pressure, and Mortality. *CLU Journal* 15:19, Winter 1961.

Robinson, P.I., Wheatley, G.M., Lew, E.A., Marks, H.H. Blood Pressure—Insurance experience and its implications. Exhibit, AMA Meeting, June 1961

Obesity

Marks, H.H. Influence of obesity on morbidity and mortality. *Bull NY Acad Med*, Second Series, 36:296, May 1960

Shepard, W.P., Wheatley, G.M., Lew, E.A., Marks, H.H. Overweight—Its significance and prevention. Exhibit, AMA Meeting, June 1960

APPENDIX II

1. ACTIVITIES OF METROPOLITAN LIFE WHICH SERVE TO CONTAIN THE RISING COST OF HEALTH CARE

The rapid rise of health care costs in recent years has been caused by a multitude of interrelated factors. The increase has been particularly steep in the cost of hospital care, which accounts for about a third of consumers' total medical care expenditures. This increase reflects rising construction costs, increasing prices for goods and services which the hospitals must buy, and greatly increased labor costs. These represent about two-thirds of hospitals' total expenditures. In the past few years there has been a sharp upward adjustment of traditionally low hospital pay rates, to bring them more into line with community wage levels. Introduction of new, specialized types of equipment has also required the employment of more, and more highly trained, personnel, thereby boosting labor costs still further.

Rapid technological advances have radically changed medical care, both in and out of hospitals, making it more effective but also more expensive. Growing awareness of the accomplishments of medical science and heightened public expectations regarding its benefits have undoubtedly stimulated the demand for hospital and medical services. Increased utilization has increased total expenditures. Not only are individuals purchasing more services, but they are frequently purchasing more expensive types of care—treatment in hospitals rather than at home, visits to specialists rather than to general practitioners.

Such forces leading to higher prices and increased expenditures for health care are largely beyond the control of an individual private insurance company. Indeed, on balance such developments are desirable and are evidence of the vigor of our health care delivery system. The greatest single factor in the inflation of health care costs in recent years—the tremendous increase in effective demand for health care introduced by the additional financing supplied by Medicare and Medicaid without corresponding efforts to increase the supply of services—was certainly beyond the control of the private health insurance industry.

Metropolitan life has been active, however, in the fight to secure the most economical use of the health care dollar on many fronts where its efforts can be effective. Several of these activities antedate the cries of alarm of individuals newly arrived on the scene who apparently have only recently become aware of the problem. Anti-trust constraints preclude joint actions which might be taken by

insurance companies to control costs. However, to the extent legally permissible, the Company has worked with others in the industry to improve the health care delivery system and secure more rational, economical use of resources. Examples of such joint actions will be mentioned in the description below of activities of Metropolitan Life which serve to contain the rising cost of health care.

Claims review

The most direct influence on the price of health care goods and services which can be exerted by an insurance company is in careful review of claims. Claims submitted under contracts which cover "reasonable, necessary, and customary" charges yield considerable information on trends in the cost and use of medical care. With data based on a large volume of claims arising from the day-to-day practice of medicine, an insurance carrier is in a position to identify and investigate charges or instances of utilization which are out of line with prevailing patterns. This may be best illustrated by a description of our group health claims methods and procedures.

Metropolitan has developed many procedures to insure that expenses recognized for benefit purposes are reasonable, customary and medically necessary. This has involved establishing guidelines for determining reasonable and customary charge levels and the development of claims personnel proficient in the detection of improper utilization of hospital and medical services. Our techniques have evolved over a period of many years and are based upon actual experience and the professional judgment of our Medical Division.

All personnel involved in payment processing of medical expense claims undergo an extensive training program in order to develop a knowledge of anatomy and physiology and be made aware of the normal extent of treatment required for an injury or illness and of the acceptable charges for such health care services. Graduated payment approval limits have been established to ensure a review of the larger claim payments by personnel of greater experience and qualifications who can more readily recognize those instances of possible unnecessary utilization or excessive charges by medical care providers.

Our general approach to the determination of reasonable and customary fees of physicians is based upon what the individual physician usually charges for medical services in his regular practice and also the distribution or spread of medical fees that we have observed in the particular area. We have for these purposes maintained physicians' profiles for many thousands of doctors, in which we have accumulated data on physicians' charges.

In recent years the Metropolitan has transferred large portions of its claim operations onto electronic data processing systems, which has enhanced our ability to accumulate large volumes of physician charge data. Periodically, the current data in the physicians' profiles are analyzed by geographical area and for each procedure, percentile distributions and other statistics are derived. These studies provide the basis for screening guides for physician charges for 253 specified geographical areas, and also provide a framework within which to evaluate charges for other procedures. These data, together with the individual physician profiles, are the basic tools used in the determination of reasonable and customary physician charges.

When processing claims involving physicians' fees, the first point of reference is the physician's profile. For electronically processed claims, this referral to the physician's profile is automatic, and at the present time about one-half of Home Office processed claims are by computer. If a physician has raised his fee for the particular procedure, a determination will be made as to whether the increased fee is reasonable for that physician, considering his specialty standing and other factors. In addition, it is determined whether the increased fee is reasonable for the area by reference to the screening guide. For claims which have not yet been converted to electronic processing, reference to the physician's individual profile in every case is not practicable, and principal reliance is placed upon the area screening guide. If a question remains, our customary approach is to discuss the matter with the physician, usually after obtaining the advice of our Medical Division, and if the matter has not been resolved then to refer the case to the local medical society peer review committee.

Concurrent with the review of the physicians' charge, consideration is also given to whether the medical services rendered bear a reasonable relationship to the medical diagnosis. If it appears that an excessive number of physician visits was involved or there is an unusually large volume of other services such as diagnostic x-rays and laboratory procedures, the case will be referred to our

medical advisors who exercise their judgment in appraising the pattern of medical service rendered. It frequently occurs in these cases that more data are required, either from the physician or hospital records, to substantiate the claim. If adequate supportive evidence does not emerge, medical services considered unnecessary are disallowed for benefit purposes.

With respect to the detection of hospital charges which are not reasonable, customary and medically necessary, our experience has been that certain types of confinement require closer surveillance than others. There is more likely to be abuse in connection with one or two day hospital stays, which may have been unnecessary in the first instance, or in prolonged hospital stays where the patient remains confined for other than purely medical reasons. There are various types of hospitals that present more problems of this nature than others, such as proprietary hospitals and teaching hospitals which support extensive training programs. A certain portion of a teaching hospital's expense is in the nature of medical education and research, and our claim practices are designed to insure that the teaching and research aspect does not unnecessarily prolong hospital confinements.

In some cases, to justify the need for continuing medical treatment or continued use of medication on medical expense claims, physical examinations of the claimant by independent physicians are utilized. If the result of the independent physician's examination indicates a lack of need for the continued medical treatment or medication, discussions are held with the attending physician and/or the claimant concerning the advisability of continued medical care.

The determination of whether a hospital's charges are reasonable is a complex matter. Hospital charges vary for many reasons, including whether the hospital is proprietary or voluntary, has a teaching program, or is in an area where there is an under- or over-supply of hospital beds. Our approach to the determination of the reasonableness of hospital charges has been mainly to identify hospitals which seem to have substantially different charge patterns for room and board or ancillary services as compared with similar hospitals in the community.

Another important facet of our claim control activity is our staff of claim consultants, who are Company employees stationed in various parts of the United States. These consultants are experienced in all aspects of claim control, and have firsthand knowledge of providers in their areas. When financial reviews of experience in a given area reveal abnormal increases in the level of benefit payments, these consultants, through investigation and audits, are frequently able to identify specific problems. These field representatives will then personally interview the various providers of service that may be involved and exert considerable influence in correcting abusive practices.

Benefit plan design

Soundly designed benefit plans under health insurance programs can do much to encourage efficient use of medical facilities and personnel. In contrast, coverages which require the insured patient to be hospitalized in order to collect encourage inefficient use of expensive hospital facilities and waste of limited insurance funds.

In the early development of health insurance, emphasis was placed on first-dollar coverage for expenses incurred during hospitalization. Promotion of this pattern of benefits by Blue Cross is not surprising, in light of that organization's close ties with hospitals. Continued adherence to this pattern by many labor unions and their resistance to the introduction of modest co-payments has inhibited the adoption of comprehensive coverage which would provide benefits both in and out of hospital. Even when policies are expanded to include benefits for ambulatory care, with some co-payment, there is often opposition to the inclusion of comparable co-payment arrangements for hospital care, with the result that the incentive to seek care on an inpatient basis remains.

For many years, Metropolitan Life has stressed the value of medical expense coverage which would pay for needed care regardless of where it is provided so long as it is rendered by qualified personnel in acceptable facilities. The Company was a pioneer in developing single plan major medical coverage, which achieves three related goals. It is conducive to economical use of health funds, it goes far to meet the public's demand for comprehensive care, and it stimulates the development of needed types of medical facilities by providing payment for services in such facilities.

We were among the first insurance companies to write major medical insurance supplementary to basic coverage. Major medical policies provide truly comprehensive coverage and protection against catastrophic medical expense.

By covering service received on an ambulatory basis, such policies encourage the use of the least expensive type of care appropriate to a patient's needs. For example, benefits for diagnostic and laboratory tests that are preformed on other than an in-patient hospital basis help to eliminate unnecessary hospital confinements.

We have been prepared to underwrite plans which would provide reasonable first-dollar coverage for medical services provided outside of a hospital such as diagnostic x-rays and laboratory examinations, doctors' office and home visits, prescription drugs and others. Many years ago we adopted a form of preadmission testing in connection with our hospital expense policies by providing benefits for certain pre-hospital diagnostic procedures. More recently, as surgi-centers have been developed where minor surgery can be performed without hospital confinement, we have reimbursed services performed in such facilities.

Deductibles, intended to eliminate small claims and thereby reduce administrative costs, and coinsurance, designed to stimulate the insured patient's interest in keeping costs down, are important weapons in the fight against unnecessary health care expenditures. They make it possible to spread the available premium dollars more intelligently to provide protection against the significant costs of health care which cannot easily be met from the family's budget.

Consumer health education

Major health problems in America—arteriosclerosis, obesity, hypertension, maiming and slaughter on the highways, drug and alcohol abuse, venereal disease, much mental illness, and many cancers—are the result of the life-style or ignorance of the individuals affected. New expenditures on health care or efforts to restructure the health care delivery system will do little to reduce death and disability from these causes. What is needed is effective health education for the public.

Dr. Victor Fuchs has suggested that "the greatest potential for improving the health of the American people is not to be found in increasing the number of physicians, or forcing them into groups or even in increasing hospital productivity, but is to be found in what people do for themselves." If people know how to maintain good personal health and living habits, and are motivated to assume this responsibility, their need for health care will be minimized. Further, if they are informed as to the most effective way of using available services when needed, efficiency and economy will be enhanced.

For more than sixty years, Metropolitan Life has engaged in a broad program of public health education.

Improving the health care delivery system

Metropolitan Life has been actively engaged in extensive staff studies relating to health care delivery. Interest was aroused initially by the promise to reduce demand for expensive in-hospital care held out by alternate health care delivery systems such as prepaid group medical practice. The Company felt that the advantages, and drawbacks, of such systems could not be honestly evaluated without practical operating experience. A variety of concepts and different organizational arrangements needed to be tested in actual practice.

The first sizable commitment was made in 1968, when Metropolitan announced its support, through a grant, of a demonstration ambulatory health care project at the Washington University School of Medicine in St. Louis. The amount of this grant is \$100,000 per year for a five-year period. The purpose of our support of the demonstration program is to encourage experimentation to determine a better means of delivering ambulatory medical care. The project is designed to analyze the reported economies involved in increased emphasis on ambulatory care. It will provide data on variations in utilization rates between the demonstration group members and a control group of non-members and information on the costs of care in a group practice setting as compared to other modalities.

Metropolitan was instrumental in forming the patient population for the demonstration program, as well as the control group. In addition to the grant, Metropolitan is supporting the project with Company personnel and other resources, and the experience is being statistically analyzed by the Company. In addition to data on utilization and costs, the project is yielding considerable information on factors that influence consumer satisfaction, and it provides an opportunity to sharpen administrative and data reporting techniques. This practical knowledge will be useful in developing and encouraging participation in innovative health care delivery systems elsewhere. As a further by-product,

the project has indicated certain areas in which medical education should be revised to meet the health care needs of tomorrow.

The Company has revised its procedures in order to make the services of prepaid group practice, in areas in which it already exists, available to employees insured under Group insurance policies. The option is offered to employees by which they can elect to have their medical care rendered by the group practice facility in lieu of the conventional method of solo practice of medicine. This is somewhat different from dual choice as it is usually known in connection with prepaid group practice plans. The more familiar dual choice arrangement usually involves withdrawal from the Group insurance plan and enrollment under the prepaid group practice plan. Under the option approach, the insured can elect to have his care rendered by the facility and remain insured under the Group policy. The Company enters into a contractual agreement with the group practice for the covered care either on a capitation basis or a seratim basis, thus eliminating claim processing and its expense.

There are other advantages to the option under the Group policy approach, through the greater flexibility that is possible. Frequently, for persons who make a group practice election, an extra contribution is required since the typical benefit packages of prepaid group practice plans involve a broader range of benefits than under the Group insurance plan with more stress on "in-full" medical coverage and the inclusion of preventive medicine. The necessity of having to pay an additional contribution is a deterrent to many families, especially if the benefits available under their Group insurance plan are non-contributory. It became apparent to us that if the group practice facility were sufficiently flexible and were willing to offer to employees benefits which are the same, or nearly the same, as those available under the Group insurance plan, then the employee could elect to have his care rendered by the facility without the necessity of paying an additional contribution and hence, the group practice plan would be more attractive. In our opinion, an arrangement which encourages consumers to try alternate forms of health care delivery is desirable, so that through experience those forms which are most economical and responsive to the patients' needs can be identified.

Metropolitan has assisted in the expansion of prepaid group practice in Columbia, Maryland, by offering an optional arrangement under a Group policy covering employees of a national firm which is building a new plant in the community. The Group policy provides a comprehensive major medical plan which involves a \$50 annual deductible and coinsurance amounts on most out-of-hospital medical services. The Columbia Hospital and Clinics Foundation agreed to provide substantially the same plan of benefits as under the Group insurance plan and went further by including preventive medicine as a covered medical expense.

The employees of this policyholder who live in the Columbia area now have the opportunity to elect under the Group policy to have their medical care rendered under what we have called the Columbia Medical Plan Option, and there is no extra contribution required. We also make available a rider whereby for an additional monthly premium employees who have elected the Columbia Medical Plan Option can eliminate the deductible coinsurance and receive all of their hospital and medical care on an in-full basis from the Columbia facility. We feel that this arrangement is attractive not only to the employees, but to the group practice facility.

To coordinate the work of Company personnel engaged in the development of new health care delivery system, a special task force has been established. The membership of this task force has been drawn from several departments, including Group Sales, Actuarial, Administration, Claims, Legal, Medical and Electronic Data Processing. Several of the members of the task force have already been exposed to ambulatory health care systems through the Company's involvement in the Washington University program and with respect to the plan in Columbia, Maryland. Various members of this task force have the responsibility to develop suitable marketing materials for ambulatory care facilities, establish various administrative procedures, appraise the quality of ambulatory facilities and resolve any legal matters in connection with offering options under Group health policies. The task force is actively working on several assignments in this area, including the projected hospital and ambulatory health care center in Pittsburgh known as Central Medical Health Services.

The Company also supports and actively participates in industry-wide activities to promote the sound development of various kinds of health maintenance organizations, under the aegis of the Health Insurance Association of America.

Considerable staff time is spent in the work of the HIAA committees dealing with various aspects of the subject. It is conservatively estimated that the number of persons at Metropolitan currently spending part or all their time in relation to the development of HMOs and other health care delivery systems is such that approximately \$150,000 of annual expense is being incurred by the Company.

Support for Comprehensive Health Planning

Planning for the rational coordination of community health services, if effectively implemented, is the key to optimum allocation of health care resources. Without such planning, wasteful duplication of facilities and services ensues.

Metropolitan Life has strongly supported the health insurance industry's program to promote Comprehensive Health Planning (CHP), carried on under the aegis of the Health Insurance Council (HIC). Metropolitan employees are active in the work of HIC comprehensive health planning committees at the national and State level.

Metropolitan employees also serve on at least six areawide CHP councils and one State CHP council. Contributions were made primarily to new agencies during their organizational phase. However, the Company continues to make some grants to CHIP agencies.

Metropolitan also supports the objectives of comprehensive health planning by requiring, as a condition for Company investment, that a health care facility have approval by the appropriate CHP agency.

Improving Hospital Reimbursement Methods

Present inequitable arrangements for third-party reimbursement of hospitals, whereby care of patients covered by Blue Cross and government programs such as Medicaid is reimbursed at rates lower than those charged other patients, are often defended as a means of controlling costs. It is said that the rates negotiated for Blue Cross patients and beneficiaries of government programs cover only "allowable costs." However, allowable costs are so defined that they fail to cover the full necessary costs of hospital operation. Such reimbursement arrangements do not control costs. They simply encourage hospitals to shift costs not paid for by Blue Cross and government programs to the bills of patients who are covered by insurance companies or who pay their own bills. These patients, in effect, are subsidizing Blue Cross and the government programs. The cumulative effect of underpayment by Blue Cross, Medicare, Medicaid, and other government programs is such that in many areas insured patients are paying charges which exceed Blue Cross reimbursement for the same service by 25 percent or more.

To narrow this discriminatory gap somewhat, we have endeavored to negotiate reimbursement contracts with hospitals in areas where we have large concentrations of insured lives. Under such an agreement, Metropolitan Life makes an advance payment to the hospital, thereby easing the institution's cash-flow problem, and thereafter makes prompt payments directly to the hospital for services rendered to insured patients. In return, the hospital grants a slight discount from billed charges. Such an arrangement simplifies claims processing and reduces the cost of administration.

However, hospitals are generally reluctant to enter similar reimbursement contracts. They point out that patients with insurance company coverage are the largest single source of revenue from which they can recoup the losses suffered in caring for Blue Cross and government patients.

While we will continue to attempt to develop such arrangements, it appears that in the long run the only effective means of eliminating discriminatory pricing and securing true hospital cost control will be through legislation to establish a program of prospective rate review. Under such a program, each institution would be required to have a schedule of prospectively approved charges, uniform for all patients, reasonably related to the cost of efficient operation.

Support for Legislation to Hold Down Health Care Costs

At the State level, to achieve hospital cost control, we support legislation to establish a program for prospective rate review. Such a program based on principles approved by the American Hospital Association and the Health Insurance Association of America, calls for the appointment of a Commission by the Governor, empowered to do all that is necessary to assure control of hospital costs to the public. The objectives of such a public authority would include (1)

adequate reimbursement for the institution, (2) price equality and predictability for the consumer, (3) incentives for efficiency in the management of the institution, (4) economy through the evaluation of the reasonableness of the institution's costs prior to changes in rates, and (5) reimbursement for capital costs which are consistent with the recommendations of the appropriate planning agencies.

At the Federal level, we support the National Healthcare Act, of which Representative Omar Burleson and Senator Thomas J. McIntyre are the principal sponsors. This bill encompasses a program for the pragmatic solution of a broad range of pressing health care problems: the shortage and maldistribution of health care manpower, the need for more—and more accessible—ambulatory health care services, the necessity to strengthen community health planning, and the urgent requirement to provide an equitable means of financing health care for everyone.

With respect to the need to contain the escalation in health care costs, the bill proposes the following four-pronged approach.

Comprehensive health planning agencies would be given the power to block public funds from going into unneeded facilities and services. Further, the cost of capital would not be a valid charge to the public by a hospital or other health care institution unless the facility or service developed by means of the capital had been certified as needed by the appropriate health planning agency.

All claims for professional services under federally supported programs would be screened against professionally established guidelines and those screened out would be paid only to the extent that an appropriate peer review organization found the service to be necessary and the fee within the prevailing limit.

Each health care institution, in order to receive payment under federally supported programs, would be required to have a uniform schedule of prospectively approved charges. All such institutions would also be required to have an effective utilization review committee, a standard system of cost accounting, audited yearly financial statements, and annual budgets. The schedule of charges would be subject to prior review by a State-estimated cost commission and would not be approved if found to be unreasonable in relation to the cost of efficient operation of the services provided.

Incentives would be provided to encourage health care benefit plans to shift emphasis from high cost hospital care to lower cost ambulatory care and to preventive care; to make judicious use of copayments so as to minimize patient demand for unnecessary services without, however, imposing an undue financial burden; and to improve benefits on a gradual, phased basis as health manpower and facilities become available and thus avoid the inflationary effect of an excess of demand over supply.

2. PLANNED ACTIVITIES OF METROPOLITAN LIFE TO CONTAIN THE RISING COST OF HEALTH CARE

The cost-containment measures previously described are all on-going activities of the Company and will be continued. The precise direction which each may take cannot be forecast, but each will be pursued as vigorously as means and circumstances permit.

Use of electronic data processing systems in claims operations will be expanded. This will enhance our capability for careful claims review, to detect and prevent unwarranted charges and payment for improper utilization of services.

We will continue to improve the design of health benefit programs and urge our policyholders to improve their coverage, where desirable.

New coverages will continue to be introduced. One of the more interesting recent developments is the prescription drug plan which became effective in the automobile industry in October 1969. Although prescription drugs are customarily included as covered medical expenses in major medical plans, the drug plan which became effective for automobile workers was a separate coverage and involved some distinctive features.

The specifications of the prescription drug plan presented a unique challenge to the insurer. It was clear from the outset that an efficient means for administering a very large volume of claims involving small amounts would have to be devised, and agreements would have to be concluded with thousands of pharmacies that wished to be considered as participating pharmacies. In order to meet this challenge the Metropolitan designed its Medi-Met prescription drug plan which has the distinction of being the first Medical Care Insurance coverage initially installed as a computerized system. The practicality of the system

lies in the fact that almost all of the paper work of claim administration takes place at the time of dispensing the drug. Each participating pharmacist has a supply of the brief claim form that is used which he sends to the Metropolitan on a periodic basis. The pharmacists receive payment each week on a bulk basis for claims previously submitted.

The significance of the Medi-Met program for this discussion lies not only in the fact that it points the way to increased economies in administrative costs, but also in the fact that it incorporates a reimbursement arrangement which brings costs under greater control. Participating pharmacists are paid the acquisition costs of a prescription plus a negotiated dispensing fee. We hope to extend the concepts underlying the prescription drug plan to cover ages for other health care services.

We expect to become increasingly active in fostering the development of improved systems for delivering health care. The volume of inquiries and expressions of interest from various groups throughout the country being received by our task force, described above, is steadily rising.

Interest in health care foundations has recently spread from the West Coast, where they originated, to all parts of the country. These organizations appear to offer advantages in controlling fees for professional services, preventing unnecessary utilization of ambulatory and institutional services, and assuring quality of care. We have been actively exploring the potential of these organizations with leaders of the movement. We are also participating with thirty-two other insurance carriers, including Blue Cross-Blue Shield, in the program of the Foundation for Health Care Evaluation in the Minneapolis-St. Paul area.

Our consumer health education programs will be continued and, it is hoped, will be reinforced by the work of the recently appointed President's Committee on Health Education. The Vice-Chairman of the Board, Charles A. Siegfried, serves on this Committee. Our Company has also provided staff for the Committee, including the Associate Director, who has been detailed to serve the Committee on a virtually full-time basis.

Senator HART. And as you go along, Mr. Siegfried, where you are turning pages and skipping some, if you will indicate the page where you are.

Mr. SIEGFRIED. Metropolitan Life Insurance Co., has a deep involvement in the business of health insurance; and medical expense insurance is a major part of this business.

However, the interest of Metropolitan in matters pertaining to health and medical care long antedates its involvement in medical expense insurance. The company organized a health and welfare department in 1909, and ever since then has been actively engaged in a variety of activities concerned with problems associated with disease and accidents and having an important bearing on the health and welfare of the people of the United States and Canada.

Attached is an appendix I in which we summarize some of the many contributions Metropolitan has made over the years through its health and welfare department.

Hence, while we have an important and extensive business interest in the subject under consideration, our interest is of a much broader and deeper nature.

We have for many years been seeking good answers to the health and medical care questions which have been confronting the people of our country, quite apart from any specific business interest.

Over the years we have sought to be well informed on all lines of thought bearing on these matters and on all developments which might favorably influence the health and well-being of the American people.

Now, I am going to try to condense the next few pages which deal with the historical development of medical expense insurance.

I try, in the statement that I have made, to draw attention to the many different kinds of organizations that have been wrestling with these questions, the variety of concepts that have been operating.

We have the Blue Cross and Blue Shield on the one hand, the commercial insurance companies on the other. The blues emphasize first-dollars coverage. They are provider oriented. The insurance companies use the insurance concept of coinsurance and deductibles.

From a very early stage we have tried to emphasize the importance of the insurance for the more serious cases. By using coinsurance and deductibles we could place less emphasis on the less severe cases and do more for the catastrophic type of case.

Now, over the years these different views and concepts have been in competition. We think this has been good. During all this period there has been a great growth in the number of people covered and in the effectiveness of the plans under which they were covered.

I draw attention, on page 6, to the fact that my experience has been with the mutual insurance company. In a mutual insurance company we do not undertake to produce any profits for stockholders or any other persons.

A further principle applies in mutual insurance operations. That is, if actual experience reveals that the premium initially charged is higher than the cost actually realized, then the excess is returned as a dividend.

Generally speaking, the insurance buyer desires to have his cost commensurate with his risk. This requires that care be exercised to evaluate and classify risks in accordance with appropriate underwriting procedures. This process has a collateral advantage of providing an incentive to individuals and groups to do those things which will contribute to improve their risk characteristics. In many cases, attention to sound underwriting has resulted in favorable cost experience, which in turn made possible the purchase of a broader form of coverage than was taken out initially. The process thus has operated to extend the scope of coverage and pave the way for advances that might not otherwise have occurred.

Then, at the bottom of the page, I discuss differences between individual insurance and group insurance, which are important. I think, to an understanding of some of our current problems.

As the name implies, individual insurance refers to policies covering a single individual or an individual and his family. Group insurance is insurance covering a number of persons, usually the employees of an employer, the members of a union or members of an association.

The group approach involves certain economies that favorably affect costs. For example, premiums are paid on a bulk basis, generally less selling effort is required, less underwriting effort is required and, particularly on employer-employee group plans, the employer performs certain administrative functions that must be performed by the insurance company under an individual policy.

There is much unjustifiable criticism of individual health insurance because the administrative costs appear high when expressed as a percentage of the premium, as compared with the corresponding percentages under group policies.

Usually these comparisons are made with large group policies, where the advantage of bulk administration is relatively more significant. But as the size of the group diminishes, the difference in cost, of course, narrows.

An important cost of any plan is the cost associated with establishing it in the first instance. This includes the cost of the selling activities, as well as the underwriting costs, the issuance of the policies, establishing the basic records, and so on. Over the years these costs have a diminishing impact on total cost. However, much of the individual medical expense insurance is relatively new and, hence, the initial costs are still an important factor.

Then I move over to page 9, and deal with the question of returns under the various kinds of policies.

A prime objective of our business is to make insurance available on a basis which is attractive and satisfactory to our customers and at acceptable costs.

The cost of insurance is the composite of the cost of the benefits that are payable, plus the cost of administration, plus the cost of taxes. As a mutual company, we do not produce a profit for stockholders or any other person.

The cost of administration must provide for such items of expense as the cost of sales and underwriting, and placing the plan in effect, including the issuance of the policy and the establishment of the basic records; the cost of collection of premiums from time to time; the cost of payment of claims; the cost of research and analytical studies; and the cost of risk-taking, that is, the charge to cover losses where the experience is unexpectedly unfavorable and the cost of other unforeseen contingencies.

We have provided information to your subcommittee showing the level of these costs for a variety of different types of plans.

The forces of competition and our business objectives exert a powerful force, compelling us to keep costs as low as compatible with our obligations for proper service and maintenance of solvency.

The facts of life are that medical expense insurance has been an exceedingly difficult business from a cost viewpoint, because almost all factors in recent years have had adverse influences costwise—the evolving character of the business, reflecting as it has rapid changes in medical practices and consumer desires; the inflationary conditions of our economy; changing patterns of consumer utilization of medical services leading to a steadily increasing volume of utilization; and the ever-expanding scope of the medical expenses that are covered under these plans.

We believe our level of expenses is explainable, reasonable, and justifiable, but naturally we also believe they warrant continuing scrutiny. We can assure you that this scrutiny is searching, detailed, continuing, and productive. It involves not only the efforts of our own people, but our customers are demanding and we respond to their desire for accountability in many different and productive ways.

While some feel costs are already high, there is evidence that somewhat higher costs might well be warranted to support additional statistical and research activities.

Also, attention is called to the fact that deficits have been incurred in a variety of sectors of our medical expense business, indicating that higher charges may be needed. This is mentioned, in part, to dispel the impression some people seem to have that medical expense insurance has been a business that is profitable or that it helps support other lines of insurance.

We do not claim that Metropolitan is unique in seeking ways to reduce the cost of medical expense insurance, but we can assure you that cost control is a major matter of concern. In the competitive environment in which we operate, it must be. It does involve a complex interplay of somewhat conflicting forces. Balance must be determined between attention to claim costs on the one hand and the costs of doing those things that can reduce claim costs. Medical expense insurance is a service business, and a good balance must be found between the quality of acceptable service and acceptable costs. We think we have been finding these acceptable balances, and we think our customers are being satisfied. It is, of course, a never-ending process.

Now, in the beginning, it appeared appropriate that an insurance company should be careful not to inject itself improperly into the many decisions related to the need for medical care, to choices among various kinds of services, et cetera. It was felt that these were matters for professionals and for the consumers. This attitude seemed appropriate, partly because in most matters of this kind there seemed to be no clear-cut right answers, and it was questionable whether the knowledge of insurance personnel and their ability to form sound judgments and decisions would be sufficiently more reliable than the parties directly involved to warrant any attempt at intervention on our part.

These matters involve the selection of physicians, hospitals; whether to seek treatment in a hospital or elsewhere; whether to seek a longer or shorter period of hospital confinement.

As our experience increased, we expanded our activities, seeking to ascertain a helpful working role with consumers—our insured—and the providers of service.

At a very early stage in the development of medical expense insurance, Metropolitan recognized that the design of the insurance could influence utilization of medical services and, consequently, the costs of the insurance and the total costs of medical care.

Because of concern on this account, we favored insurance which did not operate to influence improperly the choice of medical services selected. In particular, we designed coverage that would not require hospitalization, with its attendant costs, to be reimbursed for services that could be provided outside a hospital.

This led to our early development and endorsement of comprehensive insurance. We believe we were the first major underwriter of comprehensive insurance. We were among the first to underwrite major medical insurance, emphasizing coverage for the severe cases and utilizing deductibles and co-insurance to make insurance more effective for the more severe cases.

In the appendix I try to set forth the variety of activities in which we have engaged in our efforts to control costs and deal with the many different problems that affect utilization and the cost of medical care; I will not undertake to get into the details on that.

I would draw attention to the fact that one of these activities is the support of an experiment at Washington University in St. Louis. This is the only experiment that I know of that is being conducted under controlled conditions, to measure the medical services received by a group of people who receive care from a medical university, and serv-

ices received by a comparable group who receive insurance in the customary ways.

This is an effort to get an understanding as to the differences in utilization of services between comparable groups of people getting their treatment in different environments.

Mr. HART. I think you explained it in the appendix, but this is an experiment which has two clumps of people, each operating with the same contract benefits, and one being served——

Mr. SIEGFRIED. That's right; if I'm not infringing on my time——

Mr. HART. No; not at all; please.

Mr. SIEGFRIED. I can come back to this later, if you wish.

Mr. HART. Please go ahead.

Mr. SIEGFRIED. There has been a thought around for a considerable time that people are being confined in hospitals unnecessarily, and if we had ambulatory facilities, there would be a vast difference in the amount of hospital confinement that would be required. Well, I think over the years, data indicated there is something to this; that is, the feeling that it was an exaggerated difference.

We are seeking in this experimental program in St. Louis to ascertain what is the volume of medical services and what is the volume of hospital services that are required, if you have these ambulatory facilities and have a group of doctors who are trying to give the people just what, in their best judgment, they think is needed.

There has always been a hint that in other research programs there has been some bias operating one way or the other to make the experience unreliable. We are hoping here, having for the first time two similar groups of people being treated differently—one dealing with the Washington University medical group and one dealing with their physicians in whichever way they were accustomed to do—to learn what are the patterns, what are the differences in the kinds of medical care used and differences in the volume of services used.

Senator HART. When do you expect to get a judgment?

Mr. SIEGFRIED. Well, we have only the first year's experience, and as you might guess, with a relatively small group it is not conclusive as yet. We expect the second year's experience to be available fairly soon, and after that I think we will be able to draw some conclusions. It is a little early to draw any reliable conclusions at this point.

Senator HART. All of this will be interesting, as to what definitely will be indicated.

Mr. SIEGFRIED. Now, you have asked what our views were as to the changes that might be made in our delivery system, and the system for dealing with the financing of costs. We think the record of growth and development of medical expense insurance is one of high achievement. This reflects commendably not only on insurers but on the segments of the public which have sought more and better plans, and on the widespread cooperation of the providers of medical care.

We are, nevertheless, mindful that as a nation we have a variety of vexatious health and medical care problems. We have worked with our industry colleagues in studying these matters and trying to find ways and means for effecting improvements. Our thoughts are contained in a broad-scale program which we called program for health care in the 1970's. This is basically the same as the program contained in

H.R. 4349 sponsored by Congressman Burleson and others in the House, and in S. 1490 sponsored by Senator McIntyre and others in the Senate.

This program undertakes to deal with the major issues currently affecting the health care scene: the problems of the poor, the near-poor, the uninsurables, the catastrophic cases, and so on.

On the other hand it endeavors to be realistic—it does not purport to be a panacea to resolve every conceivable issue that affects the incredibly complex total situation. We think it is the right program for this time. We think it would be a great step forward and would move to a position from which further advances can be made at some time in the future, if they are then so indicated. It builds on current strengths and does not wipe away the many aspects of the current situation which are strong and which are functioning in a creditable fashion.

Now, you asked whether accident and health insurance policies should be standardized by regulation. The apparent simplicity and efficiency of standardization has appeal. However, there are many facets to health insurance which involve questions on which there are widely differing views. It would be exceedingly difficult to achieve standardization except arbitrarily and at substantial risk that the standardized form did not represent really the best answer. Standardization operates to make innovation, experimentation, and change more difficult, and yet at this stage of development we do not have final answers and need the opportunity to learn through variation to improve.

The program for health care in the 1970's, by establishing a pattern of minimum benefits for plans entitled to the maximum allowable deduction for tax purposes, moves as far toward a greater degree of uniformity as seems desirable at this stage.

Another question you raised was: should accident and health rates be regulated? Currently there is already an extensive degree of rules and regulations concerning various aspects of health insurance rates.

The cost of health insurance is largely determined by the cost of the medical care services covered and by the rates of utilization of covered services. Regulation can be injected into the picture in a variety of ways, and there is little doubt it would alter costs and practices and behavior in a variety of ways. It is more difficult to be sure that moves toward more regulation would really be advantageous to the great mass of people. There are still too many variables and there are still too many unknowns to give us confidence that apparent short-range efforts to reduce costs will result in the most desirable situation overall.

Here, again, we believe that the approach of the program for health care in the 1970's, is most likely to provide information and experience as a guide by which longer range moves can be considered. Then I set forth in summary form the ideas and points I have been trying to convey.

1. Health, medical care, and the matter of medical expense insurance involve a broad and complex mixture of human, technological, and business problems.

2. There are many different views as to how these matters should be dealt with in the balanced best interests of consumers, providers, those paying the costs, and the public at large.

3. Substantial and continuing progress has characterized the many developments that have occurred in a relatively short span of years.

4. Metropolitan has been a leader in these developments in developing effective plans of insurance, in engaging in a great variety of activities aimed at improving health and safety and the operation of insurance against medical care costs, and in endeavoring to make insurance available at fair and appropriate costs.

5. Reducing the cost of medical expense insurance involves the judicious utilization of numerous potentials: health education; improvement in the organization; and use of medical care facilities and personnel; cooperation among the numerous groups working in the field; improvement in the handling of administrative actions. Much also depends on the general economic, political, and business climate in which insurance is permitted to operate.

6. Metropolitan believes that the public interest would be well served if Congress enacted the measures contained in H.R. 4349 and S. 1490. Highly significant is the fact that these measures are comprehensive and deal constructively with the major matters of current concern, and they are aimed at building on existing strengths.

Now, in the statement I have just presented and in the attachments I have tried to give you the answers and the information you requested in your communication to us. If there are any questions I, of course, would be delighted to answer.

Senator HARR. Thank you for the summary.

We are joined by Senator Gurney. Some of the questions we will ask, by implication at least, will sound very petty.

Let me begin by saying that while I have been exposed to some insurance facts of life the exposure was scattered and in the form of what we hear in this hearing room. But I have developed, I hope, some appreciation of the business realities that operate on even the best motivated insurance company. I am hoping I understand that.

Is it not true that an ideal world for an insurance company would be one where you have underwriters who identify that segment—I'm talking about health insurance—that segment of the population that will never get sick, and write them and manage to leave to some other company everybody that is going to get sick. Isn't that sort of a problem that operates—

Mr. SIEGFRIED. I am not sure that I understand you; but insofar as I do understand, that isn't the world in which we live and it would be unrealistic. Of course, if you could be sure you weren't going to get sick, or you weren't going to die, you wouldn't take insurance. It is for a contingency.

If there were underwriters and other knowledgeable people who could segregate the "sure risks," maybe that would approach it, but I find it hard to think in those terms because we live in the real world where no one can be sure.

Senator HARR. Let me respond this way. I agree that the potential customer doesn't know whether he is going to be sick tomorrow or not. The insurance underwriter is not in a position to make that judgment with any degree of certainty either, and that is the real world in which you live. But the ideal world, from your point of view, would be one where the customer wasn't sure about tomorrow, but you were.

Mr. SIEGFRIED. Well, again, that is——

Senator HART. Isn't that right? You would pick the fellow that you knew wouldn't get sick, and leave to somebody or some other thing the fellow who would get sick?

Mr. SIEGFRIED. Well, this would not be the process of mutual insurance. We are not in business to make money. We are in business to deal with the risks—the problems that people are confronted with.

Now one thing that we are concerned with: when we do undertake to work in the real world and deal with people, people generally want to pay costs for their insurance that are commensurate with the degree of risk that they present to the insurance company. So our problem is not one of selecting the insurables and rejecting the others so much as it is to try and find the appropriate measure of the risk that different people present to us, so we can put an appropriate and reasonable price tag on the price of insurance for the different groups of people.

Senator HART. Now having established that I think I have explained why some of these questions will now sound petty. I do understand what the real world poses for you, whether a mutual or a stock company, in making your selections. You have a personal health insurance underwriting rules book and as I understand it, Metropolitan rates, on the basis of classification of risks, rather than on a community basis—is that right?

Mr. SIEGFRIED. You are talking of individual insurance?

Senator HART. Yes.

Mr. SIEGFRIED. I would say our object is to place a value on particular classes of risks. These range from those who are insurable at standard rates to some who will get ratings or some adjustment in the plan, to those who are uninsurables.

Let me hasten to say that I am terribly concerned about anybody who is uninsurable and that this is one reason why we feel so strongly in favor of the provisions in the program for health care in the 1970's because it is a practical solution to the problem of insuring the uninsurables in the population. This is the first time I have seen a proposal that would make insurance available to everyone in the population, and those who were insurable could get insurance at the proper price, and those who were uninsurable would be subsidized in part, depending upon what judgment society made as to how the extra cost should be divided.

Senator HART. Well, on page 1 of that underwriting rule manual by way of preliminary statement: "Those persons who have reason to expect medical expenses or to be disabled are those most likely to apply. The object of the underwriter is to select, average risks; that is, those applicants who will produce the expected claims experience and to avoid claim losses which are, to a great degree, foreseeable."

The way the lay person would interpret that is, as I suggested, that your company doesn't want to write people who are most likely to need care, or who will in all probability become sick or disabled, thus necessitating medical care.

Mr. SIEGFRIED. Again, it is aimed at our efforts to provide equity, fairness between different groups of people. It would clearly be—I was going to say unfair—but unworkable if people deferred taking out insurance until they were at the point of death or at the point of suffering a disability that involved medical expense. If only the people

who were going to get a claim took out policies, then the cost would be equal to the claim.

Senator HART. Well, in your health rate book, if I read it correctly, you identify among the uninsurables all laborers, dishwashers, carwashers, livery stable employees, unskilled employees, bootblacks and porters—now if other companies engage in that sort—shall we call it “competition” how are those people supposed to get health care?

Mr. SIEGFRIED. That is why I am for the healthcare program. There will be groups of people in the population who either don't have the money to pay the cost of the policy or they are in an impaired condition of health, quite different from the average. To include them would make the cost of insurance unattractive to the average person.

That is why we endorse a program that would make available insurance pools on a State-by-State basis, under which the uninsurable people, and people who couldn't pay for their insurance could get help to get it.

I have to readily acknowledge that we are incapable of insuring every person who needs it. Some don't have the money and some are in such an impaired condition of health, it would make the cost of insurance to other people unacceptable if you included them at standard rates.

Senator HART. And you do identify categories which are good risks, among the best risks, and you go to the other end of the span—

Mr. SIEGFRIED. Appropriate classification.

Senator HART. We wonder a lot about ourselves as a people, to just look at one of these rate books. What about a fellow that is not a bootblack or a livery stable employee, pinboy, or carwasher, but who lived in the dead center of the city—it is hard to visualize an archetypic living here but how about a local neighborhood chiropodist? They are among the best risks. Now would he be treated as a best risk, or a fellow who lived in a bad neighborhood? Would he be insured?

Does where the man live make any difference?

Mr. SIEGFRIED. Well, it creates some presumptions. We would be more concerned that a person living in the central city area, or any poor area, might be a person with low income who couldn't afford to pay the premium, or he might pay one but he couldn't continue it. So I think we would have to be more careful in looking at what other characteristics he might have that might make him insurable.

Senator HART. Let's assume he may have assured but modest income; for example, military service, retirement or pension disabilities, so there wouldn't be—

Mr. SIEGFRIED. I assure you, we are eager to insure anyone who can possibly qualify as a standard risk and has the money to pay whatever the appropriate premium is. We have no desire to exclude anyone, but we do have the problem first with regard to people who are impaired, or close to impairment, to see that they are properly classified. We also have to ascertain whether people have the resources to pay the premiums, because it is very costly to issue a policy and then find that the individual doesn't have the money to pay the premiums.

Now we acknowledge that there are people in the community, many of them, who can't get insurance because they don't have the money or they are impaired. That's why we say this program, “healthcare in the 1970's” has an answer to that very difficult question.

Mr. HART. But I'm curious as to categories of employment which range from desirable to undesirable and whether one's neighborhood is a factor in the underwriting. Imagine this—a man who is retired from the military, no disability, so he has the money to pay—

Mr. SIEGFRIED. Sounds pretty good to me.

Mr. HART. He walks into your office, which may not be located in the dead center of the core of the city, but in one of those other neighborhoods, can he get individual health insurance at the same rate as the retired military man living in the suburbs?

Mr. SIEGFRIED. It's hard to generalize, but I think I can be most responsible to your question by saying that just the place where he lives would not exclude him from coverage.

Mr. HART. What does the "red star" district mean?

Mr. SIEGFRIED. I will turn to my colleague here. I am not sure that I can—

Mr. LANCASTER. In our 20 some years or more of writing individual insurance, we have developed information as to the districts which have the highest loss ratio. These are what we refer to in our in-house terminology as "red star" districts.

Mr. HART. What are the consequences that follow from something being marked a "red star" district?

Mr. LANCASTER. The only consequences are that our underwriters are a bit more thorough in the development of the case. These cases are not blackballed in any way, shape, or form.

We take the business, we look at it. The underwriters are a bit more thorough in the development of the case, as to medical examinations or whatever.

Mr. SIEGFRIED. It costs money to underwrite, to get all the information one needs; and if one has information that makes it possible to dispense with some source of information, that helps. If you have some way of identifying where you need to be extra careful, that also helps. This is all done with an eye to the cost element for the consumer, trying to make insurance available at the most attractive cost to those who can qualify for it.

Mr. HART. Well, by being a bit more thorough, when that retired master sergeant comes in, what does that mean? What do you do if he walked in a suburban—

Mr. LANCASTER. I might add, Senator, that these "red star" districts are not all center city districts, surprisingly. But we have certain internal underwriting rules under which we'll obtain statements of attending physicians, or that sort of thing, or statements from hospitals, on authorization of the applicant. We learned from experience that in certain areas we are able to waive these and just forget about getting this information and go ahead and underwrite the policy; where we will ask for this kind of information in certain districts.

Mr. HART. What are typical "red star" districts?

Mr. LANCASTER. You mean locations?

Mr. HART. I suppose if you give us the locations, we'll then be able to understand what factors you are looking for when you mark something "red star."

Mr. LANCASTER. They're all over. Well, I guess the best way to respond to this would be to tell you what the districts are. We have them in most parts of the United States. That is, they're scattered, and it's a bit surprising sometimes.

Mr. HART. Well, just pick two. Bedford-Stuyvesant and Bloomfield Hills in the same category, and you are making available individual health policies. Is one "red starred" and the other one not?

Mr. LANCASTER. I can't answer that, sir. We have lots of districts that are center city that are not "red star."

Mr. HART. Why?

Mr. LANCASTER. Pardon me?

Mr. HART. Why is something "red star" and why is something not "red star"?

Mr. LANCASTER. Only because of the experience that we have developed from that district. We keep a record of the loss ratios by district.

Mr. HART. Individual health experience?

Mr. LANCASTER. Yes. This is just done for internal purposes. And all it is, as I say, is to be somewhat more thorough and more careful in our working.

You asked for a great deal of information. I don't know if you have a list, for example, of those districts, but if you want them, we can—

Mr. HART. It would help us at least develop an understanding, if you will. (See p. 946.)

Mr. SIEGFRIED. There's nothing really mysterious about our process. We are trying to get information with the least effort—which means the least cost—that would enable us to tell whether we have a standard risk or not.

Mr. HART. I'm glad I tried to indicate some understanding about the economics about these insurance companies. If you identify as a "red star" district a district where people get sicker more often, I can understand why you want to know that. But it also raises for all of us a question, well, how can we make provision for those very areas which are most—

Mr. LANCASTER. That's what they are, sir. They're districts that have the higher loss ratios.

Mr. HART. Mr. Sharp asked me to ask you how do you use loss ratio in that answer?

Mr. LANCASTER. It's the ratio of claims to premiums.

Mr. HART. Senator Gurney.

Mr. GURNEY. Thank you. Pursuing that subject a little more, if you included these people who lived within the "red star" district or some of these people in the categories the chairman has enumerated here as being either excluded or substandard risks, how much would that increase the premium cost to the other policyholders? Can you give us any estimate of that?

Mr. SIEGFRIED. It's difficult, almost impossible to reduce it to a figure. Persuading the American people to buy health insurance is not an easy matter. It requires a great deal of effort, and the large amount of insurance is in force because some people have found other people to pay for the cost of it.

We have, for a long period of time, recommended and advised a much broader kind of coverage than people are either willing or able to pay for. So, this is a continual struggle to construct plans and prices that people are willing to pay for. And this is a very delicate balance, and it's a matter of judgment, of course.

But based on the information we have, inclusion in the covered group of people living in these districts, or people falling on the border-

line between the excluded and the acceptable risks, would increase the costs sufficiently to make the price unattractive to people.

And so, as you raise the price, you diminish the number of people who will be willing to buy it. And this is the essence of the business problem.

Now, all of this comment has been in the area of individual insurance. I should hasten to draw attention to the fact that this is a relatively small part of the total of medical insurance which we're talking about.

In the group area, because we are bringing large groups in, we can be less concerned about the inclusion of the borderline risk.

Mr. GURNEY. That's the next question I was going to ask. What is the percentage of your business which is group business and that which is individual business?

Mr. SIEGFRIED. Mr. Thomas has shown me a figure here that is 85 percent as group and 15 percent as personal. I would have had to think longer if he hadn't indicated.

Mr. GURNEY. So, what we have been talking about here is the 15 percent portion?

Mr. SIEGFRIED. Yes; but I don't mean to diminish the importance of trying to make insurance facilities available to people who are not associated with groups.

Our efforts to develop individual policies, have been aimed at trying ways and means of making a policy available able at a price that those people can pay.

Most people who are covered under a group policy have the advantage of having their employer pay part of the cost, or the employer pays for the cost of administration, which the person under an individual policy doesn't have.

And so, we have to be ever so much more careful to tailor the plan in a way that makes it an acceptable product.

Mr. GURNEY. But as far as group is concerned, we'll say perhaps your company insures General Motors or some other large concern like that, all within that group. All of those employees covered by the insurance policy, whether they were good risks or bad risks, would be included, is that right?

Mr. SIEGFRIED. We'd make no distinction; yes, sir. The fact that people are employed is a very important element of selection in the first place. People who are insured under an employer's group are, for the most part, people who are working, at least, when the plan goes into effect.

Mr. GURNEY. I suppose these categories which Senator Hart mentioned before, some of these may be included in some of those group policies, is that right?

Mr. SIEGFRIED. Yes; yes indeed.

Mr. GURNEY. In other words, if you've got a shoeshine boy in the General Motors plan, he's covered by the policy?

Mr. SIEGFRIED. That's right.

Mr. GURNEY. Again, back to the original question though, I understand, and I'm sure all of us do, the competitive aspects of trying to market a health policy or anything else, and it comes to the point of price where people resist.

Again though, is there any ballpark figure that you can give that would increase the premium if you included all of these substandard risks?

I know you said it would be more, and in your opinion, people would resist the cost of the policy, but I'm saying, can you give any estimate?

MR. SIEGFRIED. Well, it wouldn't be a responsible response if I did. I would hazard a guess it could increase costs 50 percent or even more.

MR. GURNEY. It would be a substantial increase.

MR. SIEGFRIED. And I would like to emphasize that we're dealing not only with the problem of medical impairments, but we're dealing with ability to pay. And one of our difficult problems in marketing individual insurance is the fact that people take out a policy and then they let it lapse.

Now, we try to do business with people who can continue their insurance because this matter of taking out insurance and letting it lapse is a costly matter. It's a wasteful thing. We try to avoid it.

If we let down the bars and we take many of the occupations you listed there and people who have borderline economic status, the lapse rate—the cost of dealing with the failure to pay—would be a very considerable amount. And it's particularly in that area that I'm unable to make an evaluation to respond to your question.

MR. GURNEY. Incidentally, this is a matter of curiosity for me, but Senator Hart mentioned about the insurance companies betting on somebody's health. And I suppose if they were in an ideal situation, they'd get all policyholders that never had a health claim.

MR. SIEGFRIED. Well, I disagreed with that. I said that's not the—

MR. GURNEY. Just to reintroduce the subject again, how many claims do you pay for health in your company?

MR. SIEGFRIED. Do you mean dollar volume?

MR. GURNEY. Both claims individual and dollar volume.

MR. SIEGFRIED. It's somewhere over a billion and a half dollars a year that we're paying out. I could provide you with the exact figure, but that's roughly the magnitude.

MR. THOMAS. That's it.

MR. LANCASTER. That's group and individual.

MR. SIEGFRIED. We're dealing with a large cross section of the American people. We're dealing with all kinds of risks in all parts of the country.

MR. GURNEY. I just wanted to bring out that the betting you do that somebody is going to be healthy isn't all that good. You're paying out a billion and a half in claims each year.

MR. SIEGFRIED. We feel that's what we're in business for.

MR. GURNEY. Earlier, in some of the testimony here, the question came up as to whether the consumer really knows what he's getting when he purchases an insurance policy. That's often a charge leveled at the insurance company, that they are bilking the customers because the customers really don't know what they're getting. Could you comment on that, as far as health insurance is concerned and as far as your company is concerned? What do you do to help inform potential purchasers of what they may be buying, or perhaps of what they ought to buy?

MR. SIEGFRIED. I can speak, most certainly, from my own experience in what we have tried to do. And we acknowledge that it's an uphill struggle to inform people adequately.

We try in the first instance to make our policies understandable. I worked on contract drafting for a long time, and I was exposed to a lot of criticism for obscure wording, but it's not easy to define precisely what you mean without using more words than some people think are necessary. But I assure you that great effort is exercised in the first instance to draft clear-cut policies. Now, some of this involves a concept of not making the plan too complicated, keeping the plan reasonably simple so it is comprehensible to people, quite apart from the words you use.

We try to be very careful in the training of our agents and in the literature that we give them.

As Mr. Thomas indicates, a very important part of our business is our group plans. And here, we work with employers to provide posters and leaflets and things which will inform and help people inform themselves as to what they have.

We have every desire to have people understand what they have because the troubles arise when they don't know what they have. And the best way to go about this is to inform them in the first place in advance, and not wait until there's a claim or some difficulty and then have the misunderstanding develop at that point.

So it's, again, a never ending process, but I assure you that a great deal of attention is given to this and it is a matter of thoughtful concern at each step of the way.

Mr. GURNEY. What you're saying, I suppose, in other words, is that the satisfied customers go to make health claims and get them paid at least reasonably satisfactorily in their own minds is, that is much better for your business?

Mr. SIEGFRIED. That's right. They certainly are.

Mr. GURNEY. We had long discussion here at one of the hearings about cost of health care. Not the cost of insurance premium or insurance policy, but cost of health care generally.

We all know that these costs are going up, and I know Mr. Woodcock, who testified here on behalf of United Automobile Workers was very critical of insurance companies in this area, trying to—they made no effort to control health costs.

Would you care to comment on that?

Mr. SIEGFRIED. Yes, I would be very pleased to. And I have attached as an appendix to my statements, a fairly long description of the many things that we have been doing, growing out of our concern for what can we do to keep medical care costs down.

This is an incredibly complex matter we're dealing with. We have to recognize that medical science is not static. We have been experiencing over the last several decades a great increase in medical knowledge, new techniques, new drugs, new—all sorts of things for dealing with all the many different kinds of health conditions that exist.

Now, most of these new things cost money. Is this good or bad? Should we discourage discovery? Should we discourage the advancement of science, or should we try to work with it? Well, we've been trying not to discourage scientific development, but this has contributed immeasurably to cost.

There's been a trend over a long period of time toward utilization of hospitals. Many years ago, hospitals were resorted to only rarely in the last extreme. We're now in a period where most every condition

seems to need treatment in a hospital. There are not many people who are willing to say that that's a worse kind of treatment than treatment outside of the hospital.

The new science seems to call for treatment in the hospital, as contrasted with treatment in the doctor's office. But we have been meeting with doctors and consumers and others trying to wrestle out what is a good way of finding a balance between treatment in the high cost hospital and treatment outside of the hospital. We currently are urging and encouraging experimentation, investigation of whether we can deal with many situations outside of the hospital on an ambulatory basis just as effectively as in the hospital.

I referred earlier to this experimental program we're involved in at Washington University in St. Louis. There are a number of others. We think ours has some attractive features that others do not have, but there's a lot of experimentation going on, trying to find better ways, less costly ways of dealing with medical care conditions.

And as you'll see from this summary that I've provided, we've been involved in this very deeply, consulting with all the people who might have anything to contribute.

Unfortunately there's conflicting viewpoints among the professionals. And it's not as though we are sitting back indifferent to what's going on. We are probing, trying different approaches, different plans, supporting different experiments to try to find some way of making the total bill much less burdensome.

So, I think—and I'm speaking here not only of Metropolitan, but of the insurance business generally—a tremendous amount of work has been expended over the years and is being expended currently in trying to find good answers to these very, very complex problems.

MR. GURNEY. The costs of hospital administration itself—I suppose there are cases where some hospitals are administered well with costs at the same level, and perhaps others that are not administered so well, and their costs are considerably higher.

Do you go into this at all?

MR. SIEGFRIED. Yes; yes we do. We have some proposals that are incorporated in our health care program that deal with this matter of hospital costs, and insist on hospitals operating on predetermined budgets.

We have a variety of things like that. I think there's no important area that we haven't probed or dealt with in this search to try to find better ways of dealing with this difficult situation.

MR. GURNEY. I remember we also had discussion previously on certain doctors that perhaps might be overeager to perform certain operations and, or perhaps more than the necessary services.

How do you monitor such a situation as that, to hold down costs?

MR. SIEGFRIED. Well, as a result of the experience we've built up over the years, we have certain norms which we use as a basis for establishing our premium rates initially.

In other words, we have a pretty good notion as to what kind of costs and utilization we should expect in advance. Now, if actual experience shows that more people are going to the hospital than we expected, or they're staying longer or the doctors are charging more than we expected to pay, or there are more visits of one sort or another, then we have a variety of skilled personnel that we bring into play

to look over what is going on, to probe as to what may be the cause of the high costs.

And frequently, it's because somebody hasn't been paying as much attention to what's going on as possible. Sometimes the causes are very complex and there's not much you can do about it. It reflects something of a basic condition in the group.

Mr. GURNEY. One more question, Mr. Siegfried. We've had testimony also, last time we met, on an organization known as the Medical Information Bureau. Has this been touched upon earlier?

Mr. HART. (Shaking head indicating "yes").

Mr. GURNEY. And there was some question as to whether the information that was fed into this Information Bureau would be accurate or inaccurate, and then, of course, acted upon by insurance companies to the detriment of the individual if the information was inaccurate.

Could you go into that and explain a little about how your company uses this?

Mr. SIEGFRIED. I'd be very happy to. And Mr. Lancaster here is even more familiar with it than I am, and if I say something that's not right, or inadequate in my reply, Ed, I'll call on you.

But very briefly, I would first like to draw attention to the fact that this organization is a mechanism for helping us in underwriting and determining whether people are properly classified for insurance or not.

If anyone had a good memory and was careful in responding to our applications, we wouldn't need any agency of this kind. But unfortunately, people have a way of forgetting, and you can't always tell whether it is willful or just accidental. We do find that in a sufficiently large number of cases, people do not bring to our attention information they should, so that we can make the kind of evaluation that is appropriate if we're going to deal with those people on a fair basis.

The Medical Information Bureau functions merely to provide an alert or a flag, if you will, to the underwriter, that somebody else has found something that has not appeared in the answers by your particular applicant. This is a cooperative arrangement between underwriters to make available a common source of alerting. Now, under the system as it's setup, all we look to the MIB for is this alert.

If there is a code, or condition, then we're in a position to pursue a line of investigation or not, as we choose. But the information that's in the system is of a very sketchy sort, and not intended to be detailed, intended merely to be a flag to the underwriter.

And similarly, the information we feed into the system is on a very sketchy coded basis. So, there——

METROPOLITAN LIFE: MEDICAL IMPAIRMENT GUIDE FOR HOSPITAL, SURGICAL AND MEDICAL EXPENSES UNDERWRITING

This shows even though a person's current blood pressure reading does not call for loading of premium, the evaluation may be affected by a previous MIB history of blood pressure.

15. Blood Pressure

The rulings for blood pressure ratings are intended for current readings or readings within a year. We cannot arrive at a rating for a level of blood pressure determined over one year ago. In cases where we need a current reading, we must order a medical examination requesting the examiner in all cases to

send a urine specimen to the Home Office. The Underwriter should request a "Thiazide test" by the letter "T" in the appropriate place. The Underwriting Services Section will then prepare a label for the specimen bottle in the manner necessary to make sure that this chemical test is made. When the report is received, it should be referred to the Medical Division.

Even though the current reading does not call for a rating, the evaluation may be affected by a previous MIB history of blood pressure or by a history of treatment for blood pressure. Such cases are to be referred to the Medical Division.

If a hospital statement indicates a diagnosis and treatment for a condition other than elevated blood pressure, but shows an incidental elevated reading, this may be a temporary reaction incident to the primary illness. Such histories should be referred to the Medical Division.

16. Diabetes

If the application indicates medical treatment within a year and that the onset was after age 15, we may proceed to order a 281 form. If the treatment in the application is more than one year ago, we should decline. When declining, we should write to the District Office as follows:

"The application indicates that ——— has diabetes, but has not received medical treatment since ——. We can consider only those diabetics who are under adequate control and this cannot be assumed unless a physician is consulted periodically, preferably at intervals of no longer than six months."

However, if there is doubt about the diagnosis, we can get a 281 even though the treatment is over a year ago.

MR. GURNEY. Let's take an example. Perhaps it doesn't go into the health policy field, but I think it will, perhaps, illustrate.

Let's say some customer came to you and asked to take out a life insurance policy and you asked a bunch of questions, among which was, perhaps, a question of whether he ever had any heart ailment or illnesses, and he said he had not.

And then you get the information from the Medical Information Bureau, and it turns out that he did have a heart attack maybe 5 years ago. So, then what would you do?

MR. SIEGFRIED. We would get from the MIB code, or a note that somebody had found that some heart condition, existed. Now that is a flag to us, that is an alert that there's something there that we haven't gotten. Then we proceed to make an investigation, to go back to the man's doctor and/or the hospital or whatever seems appropriate under the circumstances, to ascertain the correctness—or the incorrectness—of the code.

If it proves that he did actually get some treatment, had a condition that we were not aware of, we are then in the position of being able to verify it.

And on the other hand, if our investigation revealed that it was an error, that this alert was incorrect, then we would have an obligation to feed that information back to the information Bureau to get the record straight.

MR. GURNEY. In other words, you don't turn down his claim because you have thoroughly checked that point out?

MR. SIEGFRIED. That's our practice; yes, sir.

MR. GURNEY. I have no further questions at this time.

MR. SIEGFRIED. Mr. Lancaster reminds me that in order to keep things fairly current, the records are wiped clean every 7 years. Any history or record of an occurrence prior to 7 years has been wiped off.

MR. HART. Mr. O'Leary.

MR. O'LEARY. It's my understanding, sir, that the Metropolitan insures the General Electric employees. Is that one of your group contracts?

MR. SIEGFRIED. We have the medical expense insurance contract covering General Electric employees; yes, sir.

MR. O'LEARY. And I would imagine the benefits covered under that plan are quite extensive?

MR. SIEGFRIED. That was one of the early, maybe the earliest comprehensive plan of which I have knowledge.

MR. O'LEARY. Well, could you give us an idea of the nature of the benefits that are provided under that plan?

MR. SIEGFRIED. I could, but Mr. Thomas is much more closely related to that. I'd like to give him the opportunity to respond to that.

MR. THOMAS. Thank you. In brief, the plan provides for full semi-private care for 365 days, and I believe it provides full payment of surgical fees on a reasonable and customary basis.

After that, after a simple \$50 deductible paid, I believe, 80 or 85 percent of all covered medical expenses, that is, all types of medical expenses except for a few exclusions, up to a maximum of \$100,000 in benefits.

Is that enough detail?

MR. O'LEARY. For the benefit of the record, what about dental expenses; would the plan cover that?

MR. THOMAS. Dental expenses?

MR. O'LEARY. Yes.

MR. THOMAS. It covers a range of dental expenses; yes, since the last negotiation.

MR. O'LEARY. Would such things as drugs—

MR. THOMAS. Prescription drugs, drugs requiring prescription from a doctor, have been covered since 1955; yes.

MR. O'LEARY. And would X-rays or private nurses, if needed, be covered by that kind of a plan?

MR. THOMAS. Yes, sir. Yes, sir. Have been since 1955. I don't want to repeat that but—

MR. O'LEARY. Now, suppose one of those employees loses his job, and I imagine there's some sort of an opportunity that he has to convert from group to an individual policy?

MR. THOMAS. Yes; he has.

MR. O'LEARY. And can you give us an idea of the benefits which would be offered to him under an individual policy?

MR. THOMAS. As I understand it, there would be—yes, I'm not that familiar with conversion.

It's quite a liberal hospital surgical policy. And we also have a comprehensive individual policy which we make available for conversions.

MR. O'LEARY. Am I correct in assuming that because he would now be asking for an individual policy, the range of benefits would be considerably less?

MR. THOMAS. I don't know if it's considerably less, but it would be less.

MR. O'LEARY. And I would assume also that he would pay more since he was now paying for an individual policy?

Mr. THOMAS. Yes, he would pay the entire cost, whereas under the group insurance policy, the corporation pays the entire cost of the individual's insurance, and the employee and corporation share in the cost of the family coverage.

Mr. O'LEARY. Now, I believe there was testimony earlier to the effect that if a man is employed that, in and of itself says something as to his risk classification. Namely, if he is employed, he is likely to be a reasonably good risk?

Mr. THOMAS. At least he's not in a current state of ill health.

Mr. O'LEARY. So, depending upon the reason as to why he lost his job, he may risk not being able to get any insurance at all?

Mr. THOMAS. No. If he lost his job, if he terminates employment, he has conversion privileges.

There are provisions for a temporary continuance if he is just laid off. But if he loses his job or terminates employment, regardless of cause, he has a right to convert providing he applies within 31 days.

Mr. O'LEARY. All right. With respect to some of the materials that you were kind enough to provide to the staff, we note that you have a printed form letter with respect to claims that are rejected.

And as I understand it, this is a computer printed form letter, one of which reads as follows: "Your recent claim has been given our careful attention. Our records indicate no insurance was in force at the time the disability occurred, and therefore, no benefits are payable."

Could you give us a rough idea of approximately how many of these letters you'd send out in the course of a year?

Mr. SIEGFRIED. No, I don't have that figure in mind. I could try to get it, but I don't know. Do you have it, Bill?

Mr. THOMAS. No, I don't.

Mr. O'LEARY. Well, if you could supply it for the record—I take it because it's a computer printed form letter though, this is a commonplace occurrence. And my question is, do you feel this is because the people don't understand the policy, the coverage under their policy, or that when they're sick, they just want to sort of test the water and see if the policy covers it?

Mr. THOMAS. I think the fact that a computer printed form letter is used doesn't signify that any great number of them is released. Many of our group medical care claims and also our sickness and accident claims are paid by computer, so this is just a matter of production of the system, and does not indicate a great number of denials.

Mr. SIEGFRIED. Let me hazard a comment here that the fact that this is a computer form has been referred to in a way that suggests it is something less than is appropriate. We have a constant tug of war to find more efficient ways of processing all the paperwork. Being able to deal with the medical expense insurance claims by computers has been regarded as a great advance not only in facilitating the payment of money, expediting the payment of the claims, but also in doing it at less cost and thereby reducing the cost of insurance.

Mr. LANCASTER. Could you just repeat that language so we're sure that we respond correctly to you? I just want to make a note—the language.

Mr. HART. I think what we're after——

Mr. LANCASTER. I know what the language is on the form letter, but if Mr. O'Leary could just repeat it so I can make a note of it to be sure of the response.

Mr. O'LEARY. "Your recent claim has been given our careful attention. Our records indicate that no insurance was in force at the time disability occurred, and therefore, no benefits are payable."

Mr. LANCASTER. All right. That's fine.

Mr. O'LEARY. I'll defer to Mr. Sharp, Mr. Chairman.

Mr. SHARP. Thank you. Mr. Siegfried, we noted from your various programs set forth in appendix 1 of your statement, your company has since 1909 shown great concern for the welfare and safety of the American people. And you spell out that health education, "good personal health and living habits" in appendix 2 of your statement help people help themselves contribute to preventive care.

Isn't it true, Mr. Siegfried, that diagnosis and early treatment can also contribute to preventive health care?

Mr. SIEGFRIED. I would agree with that. It could. It could.

Mr. SHARP. You would say it would?

Mr. SIEGFRIED. I'll agree that it does, or I think it does.

Mr. SHARP. You believe that private companies must find ways to eliminate financial and other barriers to the patient seeking early and comprehensive medical treatment?

Mr. SIEGFRIED. Yes, I think so.

Mr. SHARP. Do you feel that the doctor or the patient controls the utilization of medical facilities, practices and costs?

Mr. SIEGFRIED. Yes, I think I have to. Insofar as I understand you, I think I'd agree with that.

Mr. SHARP. You'd agree that it's the doctor?

Mr. SIEGFRIED. The doctor has an important role in determining the utilization of medical services.

Mr. SHARP. And their costs?

Mr. SIEGFRIED. And their costs, yes. Well, yes, yes.

Mr. SHARP. Then you'd agree that it's the doctor who decides whether a patient goes to the hospital, which, from testimony received here before the subcommittee, is one of the most expensive places for treatment, or receives less expensive treatment on an outpatient basis? Would you—

Mr. SIEGFRIED. Here's where I think—I don't know just the line of your thought or questioning here, but here's where we encounter a very interesting development in our history.

I tried, in my testimony, to show that at the early stages, we were preoccupied with hospital treatment and care, and people took out insurance against the cost of hospital confinement. The fact that there was hospital insurance available encouraged both the policyholder and the doctor to utilize the hospital, and so we've moved into this era, when people are using a large amount of hospital services.

But now, we are aware of the cost consequences of this line of development, and now we're groping around for ways to reduce that cost. So people are concerned now, both doctors and patients, about having insurance that covers cost of medical services outside of the hospital as well as within the hospital.

And I think this is a process in which both the consumer and the doctor play an important role. Maybe at one time or another one is superior, but they're both working together.

I would agree with you that, overall, we're looking for ways and means to help people to live and behave in a way that will minimize the utilization of medical services—not only because it costs less, but because everybody will feel better if they take better care of themselves.

Mr. SHARP. In your statement you emphasize your company supports deductibles and coinsurance. How can deductibles and coinsurance control health utilization and the costs placed on the patient when it's really the doctor, not the patient, who controls the utilization and the costs of those health services.

Mr. SIEGFRIED. Well, you're dealing there with one of the areas in which we don't have all of the final answers, or don't know all that is operating.

Some people felt that the use of deductibles and coinsurance does involve the consumer, the patient, in the decision as to what kind of care he gets, and how much. I'm inclined to think that the more important aspects is that it is a way of transferring the utilization of the insurance dollar from the less important case, the less severe case, to the catastrophic type of case.

We have been strong advocates of insurance that does a good job for the severe catastrophic type of case, and the coinsurance principle and the deductible device have that effect.

Mr. SHARP. But you would agree, I take it, that once the patient—a person is in the medical system, it's the doctor who is controlling this entire process?

Mr. SIEGFRIED. The doctor has a very important and leading role, I would say. He has this whole role. And this reflected in current efforts of consumers to have a greater voice in what goes on. They certainly have a greater voice if they're covered under comprehensive plans, than if they're covered under plans that favor one kind of treatment or another.

Mr. SHARP. On page 7 of your statement, you mention that the underwriting "process has a collateral advantage of providing an incentive to individuals and groups to do those things which will contribute to improve their risk characteristics."

Does your company believe that the individual consumer alone, or as part of a group, is really in a position to judge and influence the quality and quantity of health care?

Mr. SIEGFRIED. Well, it's a matter of judgment, but when all parties involved work together and have a concern for the end result of their actions, we observe different results taking place.

And so, working in an atmosphere where people don't seem to care, or they seem to be unaware of what's going on, we observe high costs.

If forces are operating which make people conscious of the cost of their action, we find the experience improves, and so, we find it helpful not only to have the individual workers, the individual people, who are covered, interested in what's going on, but having their employers interested too.

We get remarkably wide variations in experience depending on the interest of people and what's going on. If there's a dollar advantage in having favorable experience, that seems to spur people to have an interest that they don't otherwise have.

Mr. SHARP. Each commercial health insurance company that has come before the subcommittee, generally, has talked about competition among insurance companies as increasing efficiency.

Now, health insurance premiums, as you point out in your statement, are made up of, first, health care provider costs, and, second, administrative expenses, profits, taxes, resulting from the particular company commercial health insures.

I take it we really have no quarrel with the proposition that competition among insurers may drive down claim and administrative costs under the insurance indemnification type of system that we're talking about.

The point is, however, that the consensus on the premium dollar with respect to group premiums, group premiums in 1970 were 7 billion out of the 9 billion commercial health insurance premium dollars for reimbursing medical costs.

This 90 cents is what is not being controlled under the present system because competition isn't working with respect to doctors and hospitals. In fact, it's driving up those costs.

Just how are we to effectively control doctor and hospital service costs?

Mr. SIEGFRIED. That's a question you're directing?

Mr. SHARP. Yes, sir.

Mr. SIEGFRIED. Competition works in a variety of ways, as I tried to say earlier in my statement. There's competition among a variety of concepts.

People have been favoring policies and plans that are heavily oriented in the direction of hospital and surgical benefits. We have endorsed the broader kind of comprehensive coverage.

There are some who feel very strongly that a good medical plan should pick up and pay from the first dollar of expense. There are others of us who favor a type of plan that doesn't pick up for the small amount, and pays for the catastrophic case a more helpful type of benefit.

These different types of plans involve different administrative costs and procedures, and this is the area in which there's a lot of competition.

And, well, different people have different views as to what is emerging from this. But we think that there are many lessons being learned which are operating to favorably affect cost.

I would say myself, I feel that the comprehensive type of plan has emerged as the desirable type of plan that on balance, makes benefits available at a lower cost than, say, a first-dollar-hospital-only plan.

Mr. SHARP. What you're really referring to—

Mr. GURNEY. If you will withhold a few minutes, Mr. Sharp, Senator Hart had a prior appointment, and now I have one. So, we'll take a short recess.

(Whereupon, a brief recess was taken.)

Senator GURNEY. The subcommittee will come to order. Mr. Sharp, I think you were questioning?

Mr. SHARP. Thank you, Senator.

Mr. Siegfried, we were at the point where you mentioned various systems, I believe, one being the indemnification insurance system as we know it today. Various systems are competing or vying with one another as a method of delivering care and financing that care.

You were mentioning that your company has been furthering comprehensive insurance plans which are basically the indemnification plans with which you had made some inroads and you were attempting to, as you spell out in your statement, offer a prepaid group practice alternative under a group insurance plan—group indemnification reimbursement plan.

I take it you sort of are advocating in your statement that the prepaid group practice plan in order to make it more attractive, because there are more benefits, the price may be more than the group insurance premium, you suggest that the prepaid group practice plan adopt deductibles and coinsurance in order to allow it to compete, I gather, with the group insurance.

Is that a fair summation of what you are really getting at?

Mr. SIEGFRIED. We are saying different people have different views as to what are the most effective and desirable ways of doing it. Some people think prepaid group practice is superior to the other types of insurance approach, but the fact that we were not making available our insurance plans to cover it was regarded by some as inhibiting the experimentation with prepaid group practice. What Mr. Thomas is very proud of is the arrangements that he has been able to work out so that people in a given locality can utilize the services of both—of a group practice facility, either on a prepaid basis or using their insurance.

Bill, probably you want to comment on that. I regard this as one more indication of a desire on our part to try to make different approaches available to meet the different views of our consumers. We hope that out of the experience, people will learn something that will persuade them that one way is preferable to the other.

Mr. SHARP. I think your answer is responsive. I think it is in the statement. Your rate books and manuals indicate, you surcharge many individual policyholders insurance, baby groups, I guess they are called. You surcharge them when they have medical impairments. Is that true? Is that a fair statement?

Mr. SIEGFRIED. That doesn't sound right to me.

Mr. LANCASTER. No, we don't; that's not a fair statement. We don't surcharge on the basis of medical impairment in the baby group.

Mr. SHARP. How about individual policies?

Mr. LANCASTER. The individual policy, we have some set standard premium rates for a limited number of individual impairments. Unfortunately, we have not been able to figure out how to extend this beyond this. There are no surcharges in the baby group area based on impairment.

Mr. SHARP. Under the proposal we talked about here, in answer to many of Senator Hart's questions, this so-called Burleson-McIntyre proposal which your company sponsors, how would the individual person be treated where he couldn't obtain, a group policy—that is, he wasn't working for an employer who would be offering the type of group policy specified in the bill?

Mr. SIEGFRIED. Very briefly and broadly, the concept there is that plans would be set up in the respective States to which the individual could turn if he was unable to get insurance from the company directly within certain premium ranges.

Now, the exact details would have to be worked out as to the circumstances under which you would qualify for insurance in the State pool and the circumstances under which you would be required to work through an individual insurer, but that's the basic idea, that everybody would be assured of getting insurance of some sort. Those who couldn't buy it within a certain price range from a private insurer could get it from the State pool.

Mr. SHARP. During your testimony, you mentioned availability at the proper price. According to the legislation (Burleson-McIntyre), cost to a husband and a wife with two children—these are “well” people, it would cost them \$1,150 for an individual policy, at least according to the House Ways and Means Committee.

If a father in a family of four (husband and wife and two children) had a medical impairment, he couldn't get into a State pool under your plan. He couldn't get into the State pool provided under the bill unless he was rejected by three companies who wouldn't write this father at two times or less the normal premium.

This means a policy could cost a family of four \$1,150 a year for individual policies. This is the scheme, is it not, as set up in this bill, basically?

Mr. SIEGFRIED. That's right.

Mr. SHARP. How could a family with the average income (a family of four) according to the Department of Labor, earning \$9,000 a year—60 percent of our families still earn under \$10,000 a year—how would these people afford \$1,150 a year if they were impaired?

Mr. SIEGFRIED. We are shifting our attention from the medically impaired to people who are economically unable to pay the cost of insurance. The health care program for the seventies deals with both categories. There are three really; the so-called poor, whose earnings are below a level at which you couldn't expect them to pay anything; the near poor, who could be expected to contribute only part of the cost; and the group of uninsurables.

The uninsurables will include some people who could pay their way, some people in very fortunate financial situations who are disabled or have severe medical impairments but who nevertheless could pay this—whatever the appropriate cost is.

You also have the uninsurables who would need help because of financial considerations.

So the concept of the McIntyre-Burleson plan covers the whole spectrum of categories.

Mr. SHARP. Under the bill, the demarkation point is \$5,000 or \$6,000. We are talking here of a family who doesn't fall into the category of needy—we are talking about the average person like the woman who appeared here this morning.

We are talking about the average person who is working, earning \$9,000 a year. Are you suggesting that the limits of the Burleson-McIntyre bill should be raised to cover people earning \$9,000 or \$10,000 a year?

Mr. SIEGFRIED. I think it's worthy of debate and discussion as to where the dividing line should be drawn between people who should be expected to pay their own way and those who need help. Perhaps

the line is drawn too low, but the higher you raise it, the cost problems become very formidable.

Mr. SHARP. In your statement, you say that as to large group policies, the advantages of bulk administration are relatively more significant. Today, administrative costs of commercial life insurance companies alone are around \$2 billion. Is it the logic of your position that the larger the group, the less the administrative costs and thus nearly everyone who needs health insurance should be in one joint group?

Mr. SIEGFRIED. No, quite the contrary, for a whole variety of considerations. We have so many points of disagreement as to what kinds of medical service should be covered, who should pay the cost, all the details of the construction of the plan that I've referred to.

People don't agree on what areas of medical expense should be insured and what shouldn't be insured. If everyone agreed, then it's conceivable to think in terms of a global plan, but as I tried to point out, our whole history up to this point is that there are wide differences of view as to what kind of medical expenses should be dealt with by insurance plans in the first place, and what degree of insurance is appropriate.

Some people prefer to take a minimum of insurance and take their chances. Some people are more cautious and seek a broad amount of coverage and are willing to pay substantial premiums to have that protection.

There may come a time where we are so close together in our thinking that a global plan may be acceptable. I think we are a long way from that point of view at this stage in our history.

Mr. SHARP. Your company is one of the largest writers of individual life insurance; is that right?

Mr. SIEGFRIED. Yes. We have more individual life insurance policies in force than any other company.

Mr. SHARP. In the individual life insurance field it is extremely important, as opposed to group life insurance, that your company have a physician examine me if I am an applicant. You have physicians around the country, do you not, who will examine an applicant?

Mr. SIEGFRIED. That is right. We don't utilize the services of a doctor in connection with our underwriting of every single life insurance policy. There is a vast amount of underwriting of the so-called nonmedical kind. We are trying not to use doctors unnecessarily.

Mr. SHARP. What I am getting at, you do use doctors, you have to rely, for the individual life underwriting, on that doctor in more cases than you would in a group.

Mr. SIEGFRIED. Yes.

Mr. SHARP. Thank you very much.

Senator GURNEY. Thank you, Mr. Siegfried, and your colleagues. You have a lot of useful information on the subcommittee's question. I appreciate it very much.

The subcommittee will be adjourned.

(Thereupon, the subcommittee was adjourned at 3:55 p.m.)

(Documents relating to testimony follow. Testimony resumes on p. 1019.)

METROPOLITAN LIFE,
New York, N.Y., July 10, 1972.

Senator PHILIP A. HART,
Chairman, Subcommittee on Antitrust and Monopoly,
U.S. Senate, Washington, D.C.

DEAR SENATOR HART: There were three points in our testimony where we were not able to respond at the time in as much detail as your Subcommittee wished. The purpose of this letter is to supply the details we promised during the hearing.

"RED STAR" DISTRICTS—INDIVIDUAL HEALTH INSURANCE

As explained at the hearing, "Red Star District" is our terminology for a sales district which, according to our experience, produces a consistently higher than average claim rate.

In 1964 we started an underwriting procedure which required somewhat more information on applicants in all of these districts as an additional aid in classifying applicants for insurance. Since then, on the basis of our experience, we have made various modifications in our procedures. Under current practice, the additional information is required in less than 15% of the Red Star Districts.

In all of such districts, we have a system of application testing as follows. A sample of new policyholders is interviewed within a few weeks after issue of the policy by a member of a special group of employees which has been established for this particular purpose. The interviewer will ascertain that the applicant received the kind of insurance he wanted and that he understood the import of the questions in the application and the answers he gave to the questions. If the interview shows that there was not a meeting of the minds between the applicant and the Company, appropriate action is taken. For example, we will change the policy or refund any premiums paid and rescind the policy if that action is called for.

Attached is a list of the current Red Star Districts which shows by State the particular area in which the district is located. The figures in parenthesis next to the State means the number of such districts in the State whereas the figures in parenthesis next to a particular area means the number of such districts in that area. As was explained during the hearing, the location of these districts covers the economic and social spectra of the country. Some of the districts are in the inner-city areas, some are in the middle and upper class urban areas,

CONVERSION PRIVILEGE—GENERAL ELECTRIC EMPLOYEES

An employee who leaves General Electric has a choice of several policies offering different types and amounts of benefits. One plan, for example covers hospital charges for room and board and special services and surgeon's charges according to a schedule. The former employee may select hospital room and board coverage for up to \$50 per day for 120 days and up to \$500 for hospital special services. Surgery may be covered up to a maximum of \$450 depending upon the type of operation.

A second plan is a Comprehensive In-hospital Medical Expense Plan which, in addition to coverage for hospital charges and surgeons' charges, provides coverage for private duty nurses during a hospital stay and for doctors' visits at the hospital for other than surgery. The plan provides benefits up to a maximum per individual of \$5,000 for one hospital stay or \$10,000 for all such stays. Covered medical expenses are subject to certain deductibles and coinsurance.

PERSONAL INSURANCE CLAIMS—LETTERS OF DECLINATION

Mr. O'Leary referred to a form letter used to notify a claimant that we are unable to accept a claim for payment because there was no insurance in force at the time disability occurred.

This results from the fact that on occasions a former insured presents a claim for benefits after his policy has lapsed. As was explained at the hearing, we process a great many health insurance claims by computer and some of these claims are denied payment for one reason or another. In all cases, when we are unable to favorably consider a claim, we provide the claimant with the reason for our action. Form letters are used on the very simple cases and in those instances where we believe the reason for refusing payment is quite

obvious. The form letter mentioned by Mr. O'Leary was sent out in 1971 on about 100 claims out of over 15,000 claims presented for payment. Percentage-wise, this represents about 0.7% of all claims for disability benefits presented under personal policies.

Sincerely,

C. A. SIEGFRIED.

RED STAR DISTRICT LOCATIONS

<i>Alabama (5):</i>	<i>Indiana (1):</i>
Anniston	Muncie
Birmingham (2)	<i>Iowa (1):</i>
Decatur	Council Bluffs
Montgomery	<i>Kansas (1):</i>
<i>Arizona (2):</i>	Pittsburg
Scottsdale	<i>Louisiana (8):</i>
Tucson	Baton Rouge
<i>Arkansas (1):</i>	Gretna
Jonesboro	Lafayette
<i>California (9):</i>	Lake Charles
Beverly Hills	Monroe
Chico	New Orleans (2)
Fullerton	Shreveport
Hayward	<i>Maryland (4):</i>
Los Angeles	Baltimore (3)
San Pablo	Cumberland
Sunnyvale	<i>Massachusetts (15):</i>
Ventura	Boston
West Lake, Daly City	Brockton
<i>Connecticut (7):</i>	Cambridge
Greenwich	Dedham
Manchester	Dorchester
New Britain	Everett
Norwalk	Fall River
Norwich	Longmeadow
Stamford	Lowell
Waterbury	Lynn
<i>District of Columbia (2):</i>	Malden
<i>Florida (9):</i>	Pittsfield
Coral Gables (2)	Quincy
Fort Lauderdale	Wakefield
Hialeah	Worcester
Hollywood	<i>Michigan (6):</i>
Miami	Benton Harbor
Miami Shores	Dearborn
Tampa	Dearborn Heights
Winter Park	Detroit (2)
<i>Georgia (5):</i>	Kalamazoo
Albany	<i>Minnesota (3):</i>
Columbus	Maplewood
East Point	Minneapolis
Macon	West St. Paul
Savannah	<i>Mississippi (3):</i>
<i>Illinois (29):</i>	Gulfport
Belleville	Jackson
Berwyn	Meridian
Bloomington	<i>Missouri (7):</i>
Chicago (15)	Cape Girardeau
Elmhurst	Jefferson City
Godfrey	Lemay
Joliet	St. Louis (4)
Lincolnwood	<i>Nevada (1):</i>
Oak Park (2)	Las Vegas
Peoria	<i>New Hampshire (3):</i>
Peru	Dover
Rockford	Keene
Rock Island	Laconia
Springfield	

New Jersey (24):

Atlantic City
 Audubon
 Bayonne
 Clifton
 Englewood
 Fairlawn
 Highland Park
 Hillside
 Irvington
 Jersey City
 Kearny
 Linden
 Morristown
 Newark
 Plainfield
 Raritan
 Rutherford
 South River
 Teaneck
 Trenton (2)
 Westfield
 Westwood
 Woodbridge

New York (76):

Auburn
 Binghamton
 Buffalo (3)
 Cheektowaga
 Hornell
 Latham
 Lockport
 Middletown
 Newburgh
 New Rochelle

New York City & Long Island

Bronx (7)
 Brooklyn (15)
 Manhattan (9)
 Staten Island (3)
 Long Island (22)
 Niagara Falls
 Plattsburgh
 Port Chester
 Syracuse
 Tarrytown
 West Seneca
 White Plains
 Yonkers

North Carolina (1):

Winston-Salem

Ohio (5):

Canton

Ohio (5)—Continued

Cincinnati
 Cleveland
 Columbus
 Youngstown

Oklahoma (1):

Oklahoma City

Oregon (1):

Portland

Pennsylvania (23):

Altoona
 Bethlehem
 Brookhaven
 Camp Hill
 Coatesville
 Drexel Hill
 Eynon
 Levittown
 Philadelphia (10)
 Pittsburgh
 Reading
 Scranton (2)
 Uniontown

Tennessee (4):

Chattanooga
 Knoxville
 Memphis
 Nashville

Texas (11):

Beaumont
 Corpus Christi
 Dallas (2)
 El Paso
 Fort Worth
 Houston (2)
 Longview
 San Antonio
 Waco

Utah (1):

Provo

Vermont (1):

Rutland

Virginia (2):

Alexandria
 Hampton

Washington (3):

Seattle (2)
 Spokane

West Virginia (2):

Vienna
 Wheeling

Wisconsin (2):

Milwaukee
 Racine

PERSONAL HEALTH INSURANCE UNDERWRITING AIDES

INTRODUCTION

The trainee learning to underwrite Health Insurance faces a severe challenge. He must remember, and use, a large number of rules and apply them with judgment and accuracy. He will have to acquire a degree of accuracy he once thought impossible. His job is more than clerical, since he must make decisions which bind the Company. This book will tell you the basics of this exciting job. You will find more detailed procedures elsewhere.

The function of the Underwriting Department is the selection of risks, and this means that some unfavorable decisions must be made. These decisions will affect the attitude of a great many people toward the Company and the insurance industry. The man who has been rejected, quite naturally feels resentful, not

only because he did not get the policy, but because his pride or self-esteem is injured. *He may feel that, having been rejected once, he will never be able to obtain insurance again. He should be told the reason, for his peace of mind.* This can be done in all but a very few cases *where we cannot reveal the source of our information* and those few cases should be referred to the Chief Underwriter.

If the decision is based on a mercantile report, we are required by Federal law to so inform the applicant and there is a special procedure to follow. If an applicant wants a more specific reason than "medical history", we can tell him (but not the Agent) by means of another special procedure.

Whenever we cannot approve as applied for, we should offer every possible alternative or mention that we could reconsider at a later date. We must avoid delays by starting any necessary inquiries at the earliest date possible. We have an obligation to the Agent to process his applications quickly and efficiently as we don't want to be the cause of any loss of commissions that might result from delays or improper handling.

Health insurance, more than any other form, is subject to selection against the Company. That is, those persons who have reason to expect medical expenses or to be disabled are those most likely to apply. The object of the Underwriter is to select average risks, that is, those applicants who will produce the expected claim experience and to avoid claim losses which are, to a great degree, foreseeable. However, we cannot be overly cautious and cause delays and expense unnecessarily.

The ultimate in Underwriting is to make an accurate judgment on very meager information.

This shows the importance of the M.I.B. record to health insurance underwriters.

MEDICAL UNDERWRITING

The medical phase of Underwriting can be the most interesting, but it is the part for which a trainee is least prepared.

On the basis of past experience, we have established rules, practices and guides. To learn these practices and to recognize the areas in which flexibility is permitted requires a great deal of knowledge and experience. Clearly a good basic knowledge of anatomy is important. The trainee should supplement his instruction by outside reading of appropriate books. When we review an application, the first medical problem may be the M.I.B. record on the back of the work sheet. It must be determined if the record will afford our underwriting and whether its further development is necessary.

The Underwriter should study the M.I.B. code book for an understanding as to the use of the codes. Sometimes reference to this book clarifies the code shown on the work sheet by indicating the category of the history or its severity. It must be remembered that the code report of another company cannot be used in coming to an adverse decision but instead is to be used as a guide so that we may develop usable information independent of the report.

Blood pressure readings may be listed in the M.I.B. record or we may get readings from a medical statement or examination. To find the significance of a recent blood pressure reading, we must refer to the Medical Impairment Guide and the tables which assign a point value to various readings. Even if the current reading is satisfactory, the previous readings must be considered. A similar procedure is used for overweight.

The answers to questions 11-12-13 are the principal sources of medical history in the medical expense application. Part B of the disability income application contains the questions relating to medical history for that form of insurance.

The decision as to whether to order a medical statement is the most difficult problem an underwriter faces. He must decide not only the medical significance but also whether the answer is an attempt to minimize a serious history. If he does the easy and safe thing—to order a statement on every history, he will cause extra delays and expense which will result in complaints, loss of business and extra work. If he does not order one when he should, the Claim Section may be compelled to pay an unjustified claim. The courts have held the companies responsible when they choose to accept an indefinite answer without investigation. After initial instruction, the new underwriter will become familiar with the more common medical conditions.

After being flagged by M.I.B., the procedure is described.

To show that a policy is to be issued with a rider, a mark (1) must be placed in Box 12 at the top of the worksheet. Then, about midway down, we enter in the space provided, the form number and the wording to be typed on the rider form. Several lengthy riders have an identifying number. These conditions may merely be identified on the worksheet by the appropriate rider number designation. For the individual Medical Expense policy and a Disability Income policy, the rider form is AH 62. For a family Medical Expense policy, rider AH 62F is used with the name of the person to whom the restriction is applicable. This form, AH 62F, must be used on all Major Medical Expense policies because only one policy form is used for both individuals and families. This will also apply to new policy forms to be introduced in 1971. Sometimes the rider will be limited to certain benefits or to a specified length of time.

The instruction space at the center of the worksheet is more or less self-explanatory. When Life insurance is being applied for concurrently with Health insurance, and we find it necessary to review that file before deciding on ours, we enter the date, check "Concurrent Life" and initial it. Similarly if prior Life, Health insurance or claim files are necessary for review, we enter the policy number or claim numbers wanted. When prior files are reviewed a brief summary of any pertinent information should be written on the reverse side of the worksheet so that the file will not have to be re-attached at a later date.

If a mercantile investigation is desired, we enter our initials and the date next to "Order Merc. Stress." However, if there is a past history of moral hazard, drinking or some M.I.B. code which must be developed, the specific information which we want should be added after the word stress. Likewise there will be times we will request details of duties, finances, physical conditions and various other factors. The Underwriter in ordering a mercantile to develop an M.I.B. report, should avoid using M.I.B. terms such as "Non-Conformity"—"Insurance Hazard" and use terms such as "Use of Liquor" or "Moral Hazard." For certain reasons, on medical expense applications, it is advisable to add "Residence and Business" to permit investigation at both places.

If we are ordering a mercantile on an H & S case only because of a "Red Star" district or because the Agent has not known the applicant for more than two months, we can approve, using the stamp for "Approved subject mercantile." This means that the Underwriter will not have to see the case again if the report is favorable.

Applications for family Medical Expense insurance may indicate that the wife is pregnant. A mark (1) must be placed in Box 20 at the top of the worksheet which will refer the file on the next anniversary date for premium adjustment. On applications for Major Medical Expense coverage, this need not be done if there is included in the coverage one minor since the premium change provides that no extra premium charge will be made for more than one minor.

When it is necessary to decline an application, the "Decline" box at the bottom of the worksheet is to be completed indicating which reason is to be checked on the notice to the District Office.

To further show the push of commercial insurance toward inpatient services it would be helpful to get their list of impairments which are significant for out of hospital expense coverage but not for hospitalization.

MEDICAL EXPENSE UNDERWRITING

Underwriting the medical expense application involves the evaluation of all factors affecting a policy providing indemnities for hospitalization, surgery or out of hospital medical expenses. The factors are medical history, over-insurance, occupation, persistency and occasionally a special hazard.

Appraisal of the medical history is facilitated by the use of a Medical Impairment Guide containing a list of rulings prepared with the help of our Medical Department. Impairments not listed, or unusual or complicated medical histories should be referred to a Supervisor for a decision. Some impairments may be significant for out of hospital expenses and not for in hospital benefits. The reverse may also be true. The Impairment Guide has included this consideration in the rulings.

Overinsurance is a factor in the sense that the benefits available should not exceed or equal the actual financial loss incurred. It is desirable to leave some expenses to be paid by the insured to provide a safeguard against incurring services of doubtful necessity. The policyholder should not be encouraged to remain in the hospital longer than necessary, or to incur services just because they cost

him nothing. Some of our policies include a provision for a "Deductible" amount to make the policyholder bear part of the expense and to pay only 80% of certain covered charges. Information specifying Company regulations applicable to over-insurance in medical expense insurance underwriting will be found in the "Underwriting Guide" and in the "Rate Book."

Occupation is not a serious factor in the underwriting of medical expense insurance since the policies have provisions excluding payment of any benefits which would be reimbursable through Workman's Compensation Laws or similar statutes. Certain occupations considered hazardous are unacceptable and are so designated in the Rate Book. In applications for Family coverage, it is permissible to exclude the applicant in such an occupation and issue a policy to cover the remaining family members. Certain occupations are designated unacceptable because of the unskilled type of work, such as laborers. In these occupations the application is to be declined and coverage to other family members is not to be offered. The reason for this is the applicant's inability to pay premiums when due. Early lapsing of insurance before the expense of issue can be overcome means that the policy was issued at a loss. This is commonly referred to as the "Persistency" factor.

This indicates that a drunk driver is a better risk for health insurance than a laborer or someone who lives in a poor neighborhood. If he gets drunk, stupefied, entirely out of control of his faculties not more than two times a year, he is acceptable for health insurance. But if he is a laborer he is uninsurable. And if he lives in a poor neighborhood, he is subject to investigation and rejection as a moral hazard.

Use of intoxicants should be considered in accordance with the degree of indulgence. The following chart will be useful in arriving at a decision:

GUIDE FOR RATING ALCOHOLIC HABITS

Degree of excess	Frequency	Within 2 years	2-5 years
1. Risks who present a picture of occasional alcoholic excess:			
Mild excess, just "feeling good," exhilaration or stimulation.	About once a week.....	Accept...	Accept.
Loud, boisterous, or obviously under influence, although still in possession of most faculties.	About once a month.....	Accept...	Accept.
Getting "drunk" stupefied, entirely out of control of faculties. Spree drinking. (Drinking that is carried over to the next day.)	Often than once a month.....	Decline...	Accept.
	2 times a year or less.....	Accept...	Accept.
	Over 2 times a year.....	Decline...	Decline.
	Not often than twice a year.....	Decline...	Accept.
2. Risks who present a picture of steady free use of alcohol:			
No intoxication reported.....	3 to 5 drinks daily (4 or more days a week).	Accept...	Accept.
	6 or more drinks daily (4 or more days a week).	Decline...	Accept.
3. Driving while drunk or arrested while drunk or belligerent when drunk:			
One isolated episode, accept.			
More than 1 episode within 3 years, decline.			

Moral hazard or environmental hazard can result in an unfavorable claim experience, or unfavorable lapse ratio. Serious deviations from the normal should result in a declination of the application. It will be necessary for the Underwriter to assume a completely unbiased point of view when reviewing the information, so that it would be apparent to anyone reviewing the same information, that the decision was justified. The race or national origin cannot be used as a factor in such a decision. We must follow the special procedure required by the Fair Credit Reporting Act when any decision is based on mercantile information.

On applications underwritten without the benefit of a mercantile investigation, it is then necessary for the Company to rely on the initial selection and recommendation of the writing agent. It would not be practical to investigate every applicant for medical expense insurance. There are specific rules designating the categories in which mercantile reports are to be ordered.

A list of some typical hazards revealed in investigations would be the following:

1. Drug Addicts—Sellers of Narcotics—Prostitutes—Homosexuals
2. Criminals—Hoodlums—Loan Sharks—Professional Gamblers or Associates

3. Financial Difficulty—Financial Irresponsibility
4. Business or Reputation Criticism
5. Poor Driving Record
6. Poor Environment (Immediate living conditions)

Foreign travel or residence

Our medical expense policies will pay benefits out of the United States, but a policy will not usually be issued where it is known that the applicant will travel or reside abroad for an extended period of time. Neither will coverage be issued to applicants who are temporary residents of the United States and have no intention of becoming permanent residents. Administration of insurance in foreign countries is difficult and costly. Applicants contemplating business or pleasure trips for short durations, may be given consideration subject to the issuance of an annual term basis to prevent utilization of the insurance merely for the trip.

Aviation presents a hazard only under certain circumstances. Our medical expense policies contain no restrictions for losses incurred in aviation accidents. There is an abnormal exposure, when the applicant is a student pilot, or instructor, test pilot or a pilot engaged in crop dusting. In these cases our procedure is to attach an exclusion rider to the policy limiting payment to injuries sustained only as fare paying passenger on a regularly scheduled flight of a commercial aircraft.

A GUIDE TO EFFECTIVE ADMINISTRATION OF GROUP HEALTH INSURANCE PLANS (FOR EMPLOYERS)

The chronically ill should be encouraged to seek other employment, Metropolitan Life advises employers.

B. THE PERSONNEL DEPARTMENT

The policies of the Company's Personnel Department affect claim administration and cost control. In examining personnel policies in relation to the Group Insurance Program, it is well to consider the following points:

1. Hiring practices

This is a vital factor. Claims control actually begins when an employee is hired. The assignment of an applicant to a position beyond his physical or mental capacity cannot only create a potential absentee problem, but can also add to the expense of the insurance program. A thorough preemployment physical examination is helpful in achieving proper placement of job applicants commensurate with physical capacity. It may also reveal an impending surgical operation in instances when the job may be sought solely or primarily for benefit rights. However, physical examinations alone are not sufficient to detect the chronic malingerer who does not have a serious condition and can usually pass a physical examination without difficulty. In order to learn about these persons who not only impair an insurance program but also affect production standards adversely, it is necessary to make thorough investigations into their previous records of employment. There are many mercantile agencies which do this kind of work and although it may cost slightly more than other forms of routine inquiry the results obtained should be well worth the money.

Hiring procedures for female employees deserve special attention. Studies of Weekly Indemnity (loss of time) claim experience have definitely pointed to the fact that married women are, under certain circumstances, responsible for above-average claim costs and other serious problems connected with excessive absenteeism. Very often these problems are related to home responsibilities which were not looked into at the time of hiring. Family relations, the number of children in the family, provision for care of the children while the mother is at work, and transportation arrangements for getting to and from work are important considerations which may directly affect both the employee's attendance record and job performance. Because of income tax advantages, Weekly Indemnity benefits may be very close to normal take-home pay. Some employees, who must arrange for the care of their children during working hours, may actually be better off financially if they can collect insurance benefits. Some married women are willing to accept a loss of income periodically rather than face up to the hardships of working full time and caring for their homes and families.

2. General Absenteeism

This is a problem which is closely interwoven with the control of Weekly Indemnity (loss of time) claim experience. Company sick leave requirements

should be examined to determine how they affect the insurance program. The indiscriminate granting of sick leave can seriously prejudice the handling of claims for loss-of-time benefits, as can the granting of a specified number of sick days per year or other period as a "right."

It is difficult to refuse payment on a loss-of-time claim on the grounds that the employee is able to work if he or she has already been granted authorized sick leave. In order to qualify for insurance benefits under most plans, an employee should be wholly and continuously disabled and unable to perform his usual work. If the same criteria is used for granting sick leave, this will result in a uniformity of operations which is beneficial. It is preferable to grant sick leave only when an employee has established his eligibility for insurance benefits. Leaves of absence for minor forms of illness which are not disabling might better be handled as personal leaves of absence rather than sick leaves.

This is particularly true of claims submitted from married females where the diagnosis is of an extremely vague or indeterminate nature. Very often the reason underlying such claims is the fact that the employee has become tired or run-down from the dual responsibilities of working and taking care of her home and family. This is illustrative of a situation in which the employee may well require a leave of absence for rest and relaxation but still not be wholly and continuously disabled as required in order to qualify for benefits under the Weekly Indemnity policy.

Insurance claim costs have a very close correlation with absentee problems, and high insurance costs are generally indicative of a high absentee rate. Many companies have succeeded in cutting claim costs significantly by adopting a formal and centralized absentee control program. Generally speaking such programs have been found to be most effective when:

(a) Absentee controls have a positive approach. They are aimed at helping the employee maintain a satisfactory attendance record and thus avoiding the need for disciplinary action.

(b) Supervisory personnel understand their duties and responsibilities in connection with absentee controls. A training program is often provided in order to define these duties properly and make certain that all company departments are operating in a uniform manner.

(c) Supervision encourages employees to improve on their attendance records. All employees can be talked to by their supervisors when they return to work following a period of absence. The employee can be made aware of the fact that he was missed and that the company is glad to have him back on the job. Mention might be made of any difficulties which his absence has caused.

(d) Employees with chronic conditions or other health problems which have caused excessive absenteeism are encouraged to secure necessary medical care. In some instances, it might be helpful to refer to the Plant or Medical Director for medical advice.

(e) Unreported or unexcused absences are not permitted and are subject to immediate discipline.

(f) Disciplinary measures are also provided for absences which are not considered justified. These measures usually range from an informal talk with the employee, a formal notice that his attendance has not been satisfactory, a disciplinary layoff and eventually termination.

(g) Departmental and individual absentee records are reviewed periodically to make certain that supervision is carrying out effectively the functions assigned to them.

(h) Procedures insure that excessive absenteeism will never go unnoticed. This is particularly important in connection with employees who might be classified as "chronic insurance claimants" or "chronic absentees." This problem is discussed more fully in the following subsection.

MEDICAL IMPAIRMENT GUIDE FOR HOSPITAL, SURGICAL AND MEDICAL EXPENSE UNDERWRITING

Loading or extra rating on a child with impairments is used. The Company shows concern about preventing payment of commission to the agent and charging extra premium. Also, to carry over a special rating to a conversion policy—what are the impairments calling for a 2, 3 or 5 year rating?

6. When applying a special rating and also an exclusion rider for six months, the Underwriter should use the autotape letter to the D. O. explaining that because of the high incidence of future medical expense following such a history, it is necessary not only to charge an extra premium, but also to apply a six-month

waiting period before such expenses can be covered. Without such a waiting period it would be necessary to charge a substantially higher premium which would not be practical. In the case of menstrual irregularity, we should add the fact that the policy already excludes coverage for six months and that the rider repeats this to avoid misunderstanding.

7. When applying a special rating on a Comprehensive policy, in addition to an out-of-hospital rider, the Underwriter should write a letter to the District Office explaining that the extra charge applies for the in-hospital benefits but that it is not practical to charge an extra premium high enough to cover out-of-hospital expenses.

8. When applying an extra temporary rating on a child, it is necessary to note when he reaches the limiting age. If the rating is for 2, 3, or 5 years, and if the child would come out of the coverage before that length of time, the permanent form of amendment should be used. As this is actually a temporary rating, the Underwriter should make a notation to prevent payment of commission on the extra premium. At the time we issue a conversion policy, we can charge an extra premium for the remaining number of years. A note to this effect should be placed on the file in an appropriate place, so that this will not be overlooked when the conversion policy is issued.

9. In considering a rescission on the basis of a material misstatement in the application, we are not under obligation to offer reformation of the contract on the basis of the special rating, even though the Medical Guide says that a new applicant would be so treated. The policyholder cannot be permitted to pay the extra premium after the loss to obtain full coverage. In accordance with the ruling of July 22, 1969, *all* claims will be pro-rated.

10. When the Rating Guide calls for a rider instead of a rating, we cannot of course offer a rating as a choice. When the Rating Guide calls for a rating, we should apply it without offering a rider as an alternative choice. However, if the Fieldman says the policy cannot be placed with the rating, but can be placed with a rider, we can agree to a rider. This of course, does not apply to blood pressure, overweight, and diabetes or any other condition not suitable for a rider. Once we permit such a rider, we cannot again offer a rated premium.

17. COMMISSIONS

The amount of first-year commission payable will be based on whether the rating is temporary (ten years or less) or permanent (more than 10 years). The person who calculates the rating of commission will be guided by the "Special Medical Rating Guide" completed by the Underwriter. If an amendment for two years, three years, or five years is checked, no commission will be credited on the extra premium. If the box is checked for A.H. 81.1, the permanent rider, the commission calculation will include the extra premium. There are two situations in which a permanent type of amendment will be used in the policy even though the rating will not persist for more than ten years. Consequently, a commission will not be paid on the extra premium. In these cases, the Underwriter should write under the word "permanent" the words "no commission".

The two situations are:

- (1) A rating for 2, 3 or 5 years on a child who will reach the limiting age and be deleted from the policy before the expiration of the temporary period.
- (2) When a policy is issued at age 56 or older and a permanent form of amendment is used which cannot possibly persist for the required ten years.

18. TO CARRY OVER SPECIAL RATING TO A CONVERSION POLICY

In the case of a child who has an impairment calling for a 2, 3 or 5 year rating and who will reach the limiting age before the temporary period expires, we are to use the permanent form of amendment and to mark the Guide, "No commission" as previously explained. When we issue a Conversion policy or a replacement policy to this child, we should apply a temporary rating for the remaining part of the rating period, whether it be 1, 2, 3 or 4 years. To identify these cases, the Underwriter, when approving the application for the new policy, should review the file for the Family policy to determine whether a permanent rating marked "No commission" was used in the original policy.

3. CHRONIC CLAIMANTS

The chronic claimant is always a serious drain on an insurance program. Sometimes it will be found that a very small core of employees is responsible for a large

and disproportionate percentage of benefits paid under loss-of-time coverage. At the same time, the other indirect effects of excessive absenteeism such as lost production are probably more costly to the company than the actual amount of insurance benefits disbursed.

Reference here is not primarily to those employees who have legitimate and serious conditions but rather to those with vague types of complaints which are not ordinarily disabling but which establish an excuse for drawing insurance benefits. *Malingers* are included in this group and also those who are not physically suited to the type of work they are doing or who have personal or home problems which affect their working ability.

In dealing with this problem, it is recommended that special records be kept of such cases and that these records be periodically reviewed by the Personnel Medical, and Insurance Departments. If it is mutually agreed that such action is necessary, employees should be called to the Personnel Department for a frank discussion of their employment records.

Employees obviously unsuited for their particular type of work are mostly unhappy. If no more suitable position is available, they should be encouraged to terminate their employment voluntarily. In many cases the employee's own best interest will be served by employment in another position or with another employer.

The psychological effect of such discussions should be considered. Chronic absentees will be aware of the Company's concern and will not be as likely to submit claims in the future without good cause.

4. MODIFIED WORK

In many cases employees drawing loss-of-time benefits reach a point of recovery where they are still unable to perform their usual duties but are capable of returning to a different type of work.

GROUP INSURANCE MANUAL RATE SECTION

These inserts show the company loads premium for industry, age, area and size of group. The females face the greatest loading.

RATES—GENERAL INFORMATION

This section contains general information about the factors which affect rates and the procedures to be followed in making rate quotations.

The Rate Tables in this Manual apply to brand new Groups issued on other than the Modern Security Plan basis at time of original issue. Quotation procedures on Revisions, Extensions, or addition of New Coverage(s) to existing Groups are outlined later in this section.

Please refer to "Underwriting General" regarding rates and special considerations involved in quotations on airlines, breweries, distilleries, mines, quarries, clergy, public employees, hospitals, educational systems and institutions, and transferred business.

"MANUAL" AND "TABULAR" RATES

In correspondence, instructions, etc., the terms "Manual rate" and "Tabular rate" are frequently used. These terms have the following meanings:

The "*Manual Rate*" is the rate as indicated in the schedule of premium rates shown in the following Sections, and in the Group Rate Book, for each coverage exclusive of loading for industry, etc.*, and, for Health Insurance, exclusive of Volume Discount (Volume Credits for Life insurance are an integral part of Manual Rates).

The "*Tabular Rate*" is the rate at which coverage would be written as brand new business—the rate determined from the following Sections, or the Group Rate Book, subject to the following:

Life Insurance.—"Manual" rate plus any necessary loading*.

Health Insurance.—"Manual" rate plus any necessary loading* reduced by Volume Discount or increased because the volume of combined premium is less than \$1,000 monthly.

*Loading for industry or for conditions peculiar to the individual group such as working or living conditions and type of employees or, in the case of Health insurance, higher percentage of older employees.

LOADINGS FOR INDUSTRY

Rates for industries denoted as "H.O." in the Classifications of Industries in this section, and in the Group Rate Book, are furnished by the Home Office on a case basis.

If a plan is to include both occupational and non-occupational Health benefits, (other than AD&D) refer to Home Office for rate information.

Any industry extra premium for Health insurance is expressed as a percentage to be applied to the rate for the appropriate percentage of female benefits.

The minimum extra premiums for industry are applicable if *all* the employees of the employer are to be eligible. Where only certain occupational classes are to be eligible, an occupational distribution of *all* employees, including those who are not to be eligible, should be submitted to the Home Office for the proper rating of the classes to be covered.

If a risk involves two or more industries, on one or more of which an extra premium is required, a tentative composite rate will be established by the Home Office based on an occupational analysis. The final composite rate will depend upon the occupational distribution of the employees insured on the date of issue.

The fact that some industries are not listed in the Classification of Industries should not be construed as indicating that no extra premium charge is necessary. If there is any question as to the correct premium to be charged for any industry, be sure to communicate with the Home Office before any quotation is made.

NOTE: In all cases (whether the industry is in the Classification of Industries or not) the prospect should be informed that all rate quotations are subject to final Home Office acceptance. The Home Office may, under certain circumstances, require rates higher than tabular on specific cases.

SCHEDULE OF VOLUME DISCOUNTS FOR GROUP HEALTH INSURANCE COVERAGES

1. Determine gross monthly premium based on manual rates for each form of Health coverage including $\frac{1}{2}$ of any Extra Single Premium for Immediate Maternity and Obstetrical Benefits for dependents, and any additional premium resulting because of unfavorable experience, ages or industry.

2. Compute the sum of the monthly premiums determined in accordance with (1) for those coverages which are to be combined for dividend consideration.

If the Health coverages in the Plan are not combined for dividend consideration, a separate calculation must be made for each separate coverage (or combination) not so combined, based upon the percentage adjustment applicable to the premium for each separate coverage (or combination).

3. Locate in the following table, the monthly premium bracket corresponding to the total monthly premium determined in 2. Select from the appropriate column the percentage applicable to the combined premium for the coverages for which premium is included in 2 and multiply the rate for each coverage by the indicated percentage. In determining the appropriate percentage for AD&D insurance, the sum determined in accordance with 2 shall be increased by the monthly premium for Group Life insurance with which the AD&D is combined for experience. As an example, assume a combined monthly Health premium of \$9,000 and a Life premium of \$5,000. Using the \$7,500 to \$10,000 bracket, the reduction in each Health insurance rate, except the rate for AD&D, would be 11%. Using the \$10,000 to \$15,000 bracket the reduction for AD&D would be 12%.

4. In applying the percentage adjustment mills will be retained in the final rate, i.e., the calculation will be carried to the fourth decimal place. If the fourth decimal place is an even 5 or less, it will be dropped; if not, the third place will be raised to the next higher mill.

Schedule of percentage adjustments of rates for Group Health Insurance Coverages

[Not applicable to Group Life Insurance]

Total gross monthly health premium at issue:	<i>Percentage reduction</i>
Less than \$1,500-----	0
\$1,500 but less than \$1,600-----	1
\$1,600 but less than \$1,700-----	2
\$1,700 but less than \$1,850-----	3
\$1,850 but less than \$2,000-----	4
\$2,000 but less than \$2,500-----	5
\$2,500 but less than \$3,000-----	6
\$3,000 but less than \$3,500-----	7
\$3,500 but less than \$4,000-----	8
\$4,000 but less than \$5,000-----	9
\$5,000 but less than \$7,500-----	10
\$7,500 but less than \$10,000-----	11
\$10,000 but less than \$15,000-----	12
\$15,000 but less than \$20,000-----	13
\$20,000 but less than \$25,000-----	14
\$25,000 and over-----	15

No volume reduction if employer contributes less than 10% of Health coverages. (Und. 7)

NOTE: If the Combined Monthly Premium for all Health coverages is less than \$1,000, a loading is required. See "Loading for Small Groups" in Page 4.1—Rates.

OTHER LOADINGS APPLICABLE TO HEALTH COVERAGES

Loadings for females

On all Health coverages except Insurance for Death or Dismemberment by Accidental Means, Medical Expense, Diagnostic X-ray Expense (accident only), Poliomyelitis, Additional Accident Expense Insurance and Medical Expense Insurance-Extended Coverage, *employee rates are increased if the benefits on females represents 11% or more of the total benefits.* The method of determining the female bracket is illustrated by the following example:

- (a) Total accident and sickness benefit on females----- \$2,000
- (b) Total benefit on all employees----- 5,000
- (c) $\$2,000 \div \$5,000 = 40$ percent (Use 31 percent but less than 41 percent female bracket.)

NOTE: If *all* employees are eligible for the same amount of insurance, the percentage ratio of female lives to total number of lives may be used.

Loading for ages of employees

An increased* premium may be required for Health coverages, if 15% or more of the employees are age 60 or over. If age data is unobtainable and Life Insurance is in force with any carrier, a Life Average Premium of \$1.20 or more at minimum rate without industry loading may indicate the possibility of 15% or more of the employees being age 60 or over. Such a case should be thoroughly investigated and if necessary the proposal should be qualified. The Home Office should be furnished the number of eligible employees in the following age brackets: 60-64, 65-69, 70-74, 75 and over (exact age of each employee).

*Does not apply to Major Medical since the premium rates always reflect the ages of the employees to be covered.

Loadings for geographical areas

(a) Experience under some forms of medical care insurance on employees in the areas of *Louisiana and Texas* listed below shows the need for additional premium for employees in such areas. The loadings indicated below may be waived if:

Less than 10% of the total employees are located in such areas, or the plan includes both Metropolitan Life and Accident and Sickness, or the plan includes Metropolitan Life without A & S but the Life averages at least \$3,000 per employee.

(1) Loadings for employees in Louisiana outside the city of New Orleans and certain locations in Northwest Louisiana*:

	Percent
Hospital -----	25
Surgical -----	25
P.A. -----	25
Comp. Major Medical -----	1

(2) Loadings for employees in Texas outside Metropolitan areas of Dallas, Ft. Worth and San Antonio:

	Hospital	Surgical	P.A.	Comprehensive major medical
With life only averaging less than \$3,000 (percent) -----	15	10	15	10
Without life (percent) -----	25	10	25	10

(3) Method of loading rate for the group:

The method for Comprehensive Major Medical is outlined in the Rate section for that coverage. For other coverages, individually, load the manual rate by the percentage developed as follows:

No employees in loading area ÷ Total No. employees X % shown above = % of loading.

If employees are located in affected areas of both states, the formula should be used twice and the resulting percentages added and applied to manual rate.

GROUP INSURANCE TRAINING GUIDE

This shows that after rating for sex and age, groups are required to pay an additional loading factor of 30% in Alabama, Los Angeles, Louisiana and Texas outside of Dallas, Fort Worth and San Antonio.

OUTLINE OF APRIL 1, 1970, RENEWAL RATE CALCULATION PROCEDURE FOR MSP GROUPS ISSUED PRIOR TO APRIL 1, 1968—S&A, MEDICAL CARE AND MATERNITY COVERAGES

(1) For Sickness & Accident and Maternity coverage—present rate basis, adjusted in accordance with the risk category established for the group.

(2) For X-Maternity Medical Care Coverage—Using "Book Rates" (plus 4% for Plan E):

(a) Premiums calculated for Plan at *current* area average semi-private charges.

(b) Reduced by deficiency credit according to the following table for cases where the maximum daily benefit is less than the *current* area average semi-private charges.

	Reduction per \$1 of deficiency				
	Male employee		Female employee		Dependent
	Under age 50	50 or more	Under age 50	50 or more	
Plan C. -----	\$0.069	\$0.134	\$0.029	\$0.139	\$0.176
Plan D. -----	.078	.157	.101	.157	.196
Plan E and basic hospital -----	.077	.155	.099	.154	.193

*If employees are located in Northwest Louisiana, refer for Home Office consideration.

(c) Increased by the applicable loading factor in the following areas:

	<i>Percent</i>
Alabama -----	30
Arizona -----	15
Arkansas -----	10
California (Los Angeles) -----	30
California (San Francisco) -----	20
California (outside Los Angeles, San Francisco) -----	10
Florida -----	10
Idaho -----	15
Louisiana -----	30
Montana -----	15
Nevada -----	15
Oklahoma -----	15
Tennessee -----	10
Texas (Dallas, Ft. Worth, San Antonio) -----	15
Texas (outside Dallas, Ft. Worth, San Antonio) -----	30
Utah -----	15
Wyoming -----	15

(d) Adjusted in accordance with the risk category established for the group.

(3) For coverage supplementing Medicare—the new issue flat rate of \$2.50 per month per person covered reflecting the January 1, 1970 increases in benefits will be applied at renewal.

GROUP INSURANCE MANUAL RATE SECTION

This shows that small groups with combined health premiums under \$1,000 must pay 5% higher rates.

Also, certain small groups, i.e. ad firms, colleges and universities, etc., pay 10% higher in certain circumstances.

Also, there are area loadings for California, Texas, Louisiana.

(B) CALIFORNIA AND WASHINGTON

Experience relating to the costs of medical care in certain areas indicates the need for additional premiums under Major Medical—both Comprehensive and Supplementary (EME). The affected areas, loadings and method of computation are included in Table IV of Comprehensive rates and Table V of EME rates. Because "inside" limits are included in Hospital, Surgical, PA and other fringe benefits loadings are not required for such coverages.

Loading for small groups

If the combined monthly premium for *all* Health coverages is less than \$1,000, the rates for all Health coverages are to be increased as follows:

(a) Combined Health premium less than \$952.50—increase rates by 5%.

(b) Combined Health premium \$952.50 or more—increase by the lesser of 5% or the percentage determined as follows:

\$1,000—Combined Health Premium: Combined Health Premium = % of increase.

DEPENDENT COVERAGE RATES

Flat rate, which eliminates the necessity of a census at issue, may be used when:

(1) Plan excludes maternity and/or obstetrical benefits and no contribution exceeds the flat ex-maternity rate, and,

(2) Plan includes maternity and/or obstetrical benefits and the contributions of employees with child(ren) only do not exceed the flat ex-maternity rate nor do the contributions of those employees with wife only or wife and child(ren) exceed the flat ex-maternity rate plus the full value* of the maternity and/or obstetrical benefits. Occasionally when the plan is to include maternity and/or obstetrical benefits, an employer will request that all employees make the same contribution regardless of dependent status. The Regional Supervisor may approve such requests provided (1) The employer is aware of the inequities of

*The "maternity" portion of the Flat "maternity included" rates for Dependent Hospital and Surgical are discounted to reflect that some employees have child(ren) only, and "full value" is the difference between the wife "Maternity included" and "Maternity excluded" *split* rates.

such arrangement, (2) The employer is contributing 25% of the cost of the Health coverages inforce with the Metropolitan and (3) The contribution does not exceed the flat rate including maternity.

Split rate, which requires a census at issue, may be used on *any* case but the composite rate based on the distribution of employees by family status at issue will be used regardless of whether such composite is higher than the flat rate.

Ratio Group—when there is no employee contribution for Dependent coverage, a ratio of total Dependent benefits to total Personal benefits is established at initial issue. Dependent insurance premiums are based on the application of this ratio to Personal insurance in force.

"One Dependent—Two or More Dependents" Rates—Such rates should not be proposed unless specifically requested by the employer. Generally, rates on this basis result in inequitable contributions because they do not fully reflect the family status of individual employees. The inequities are even more pronounced when maternity benefits are included in the plan.

Except in the circumstance outlined in the next paragraph, the Regional Supervisor may approve "one—two or more" rates provided the employer contributes at least 25% of the premium for all Health coverages and the employer understands (1) the inequities involved and (2) that the rates charged will be based on the actual distribution of dependents covered *at issue* and hence the preliminary quotation is only an *estimate*.

This procedure should not be used if, because of a generous employer contribution, the contributions of employees with two or more dependents are less than or just equal the standard children only rate (or husband only rate if there is a spouse definition). The standard split rates produce the same composite premium without the necessity of an involved census and, in a case of this kind, either split rates or the flat rate should be used.

Rates will be determined at issue on the basis of actual distribution of employees by family status and application of standard split rates as follows:

1. Total aggregate premiums in each of (a) and (b).

Dependent status:

(a) One Dependent Rate; Wife Only; One Child Only; Husband Only.

(b) Two or More Dependents: Wife and Child(ren); Children Only (2 or more); Husband and Child(ren).

Split Rate applied: Wife Only; Child(ren) Only; Personal Ex-Maternity rate; for less than 11% female.*

Wife and Child(ren), Child(ren) Only, Husband rate* as in (a) plus child(ren) only.

(i) Multiply the factors below by the number of employees in each salary class and divide the sum of the products by the total number of employees. The last two columns illustrate the calculation.

Salary class	Factor	Number of employees	Product
Less than \$5,000.....	0.90	80	72.0
\$5,000 but less than \$6,000.....	1.00	40	40.0
\$6,000 but less than \$8,000.....	1.10	45	49.5
\$8,000 but less than \$10,000.....	1.25	20	25.0
\$10,000 but less than \$20,000.....	1.50	14	21.0
\$20,000 and over.....	2.50	1	2.5
Total.....		1200	1210.0

* 210 over 200 equals 1.05.

(ii) If the result of the calculation is 1 or less, no adjustment is made. If the result is greater than 1, the Personal rate obtained through the application of Tables I and II is increased by 30% of the % excess; i.e., 30% of .05=1.5%. The Flat, Wife Only and Wife and Child(ren) rates must be increased by 120% of the Personal numerical adjustment.

IMPORTANT

In discussion with policyholder it should be made clear that salary adjustments based on the preliminary data submitted are only tentative and that final calculation will be made when the enrollment campaign has been completed. Hence,

the preliminary rates may change depending on the salary distribution of the employees covered for Major Medical Expense Insurance.

(2) Applicable to groups with a gross monthly premium for all forms of Health Insurance, combined for financial experience, of less than \$2,000.

No salary adjustment is required. However, for the types of cases specified in C of Table IV, the Manual rates are increased 10%.

B. Age

The standard age adjustments apply.

See "Adjustment for Ages" in General Information Section

AREA, CO-INSURANCE AND VOLUME ADJUSTMENTS LOADING FOR CERTAIN SMALL GROUPS

A. AREA

1. *The standard area adjustments apply.*—If there are any employees in California, Texas or Louisiana, see "Area Loadings" in General Information Section.

2. *California UCDB Hospital Benefits.*—Covered expenses for hospital charges are reduced by the amount of these benefits. Therefore, a credit should be given for California lives who are *insured* under the State plan. The credits for Personal coverage *only* are as follows:

	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91-100
Plan A.....	\$0.68	\$0.70	\$0.72	\$0.73	\$0.75	\$0.77	\$0.79	\$0.80	\$0.82	\$0.84
Plan C.....	0.81	0.83	0.85	0.87	0.89	0.92	0.94	0.96	0.98	1.00
Plan D.....	0.99	1.02	1.04	1.07	1.10	1.12	1.15	1.18	1.20	1.23

These adjustments are subject to the age, area, coinsurance and salary adjustments. This adjustment should be made after the salary calculation because the Dependent rate should not be affected by this integration credit.

B. CO-INSURANCE

If the insured proportion is to be 80% instead of 75% *increase* the rates after all the foregoing adjustments by the following percentages.

Plan A—8% Plan C—4% Plan D—5%

C. LOADING FOR CERTAIN SMALL GROUPS

1. If the combined monthly Health premium is less than \$2,000, the Manual rates (after all adjustments have been made) are increased by 10% in the following types of cases:

Groups where non-salaried classes of employees are excluded from eligibility and the excluded classes represent more than 15% of the total work force. Advertising Firms, Colleges and Universities, Research Organizations, Groups consisting of 30% or more of professional people such as lawyers, engineers, accountants, etc.

2. Plans covering only "key personnel" must be referred to the Home Office, with salary data, for rate consideration.

D. VOLUME ADJUSTMENT

Manual rates are subject to adjustment in accordance with volume of premium.

3. *In-Full Area after a Specified Amount*, i.e., \$2000, of Covered Medical Expenses Have Been Incurred.

Because it is highly desirable that an individual participate through co-insurance in the quality and cost of the medical expenses incurred, there is no justification for eliminating co-insurance as a claim control above any given amount and such a plan will not be approved.

4. *Hospital Employees.*

Experience under basic medical care coverages has indicated that extreme care must be used in underwriting groups of this type. Such groups will only be considered by the Home Office (at higher than normal rates) when Metro-

politan Group Life Insurance is included in the plan and the employer shares at least 40% of the cost of both the Personal and Dependent coverages or alternatively, all of the cost of the Personal and at least 25% of the Dependent coverages.

D. VARIATIONS WHICH THE REGIONAL SUPERVISOR IS AUTHORIZED TO APPROVE

1. Any Prepayment or Any Other Group Insurance Plan

Any benefits payable under the provisions of any prepayment plan or any other group insurance plan are excluded from covered medical expenses. This eliminates duplication of benefits provided by a Group insurance plan or a Prepayment plan provided on a Group basis or an individual Blue Cross/Blue Shield contract arrangement. It does not apply to individual Accident and Health insurance policies because under such policies stricter claim administration is possible and generally only nominal benefits are provided. This exclusion is made for the following reasons:

(a) The plan provides generous benefits for a wide area of expense. There is little or no need to provide additional protection for medical expenses.

(b) It is not economical for the employee or employer to maintain duplicate coverage. That part of the employee's money which is represented by his contribution for his duplicate coverage might better be used as savings for his direct payment of expenses, i.e., deductible and co-insurance.

(c) Duplication of coverages may lead to widespread increase in medical charges, as restraint cannot be expected from doctors, surgeons and other providers of medical service in assessing only "reasonable" charges if the employee is permitted to make a profit on illness.

However, in the circumstances outlined below the Regional Supervisor may authorize substitution of "any other Group Insurance or Group prepayment plan." Benefits under prepayment plans such as Blue Cross and Blue Shield will be taken into account only if received under a Group arrangement, i.e., through a plan sponsored by an employer, association of employees, or labor unions. (Additional premium is not required.)

This substitution may be made only if:

(a) The Major Medical plan replaces a base hospital plan in force with the Metropolitan or another insurance company which was adequate (not more than \$4 below Semi-private) for the area and had been in force continuously for at least three years.

OR

(b) Positive evidence is available indicating that less than 25% of the eligible employees have individual Blue Cross and Blue Shield contracts and this number is decreasing.

2. Ambulance Service

For "local professional ambulance services"—The Regional Supervisor may authorize substitution of the following.

Professional ambulance service when used to transport an individual from the place where he is injured or stricken by an illness to the first hospital where treatment is given—but no other charges for transportation or travel.

This is not a liberalization in all cases since ambulance service is restricted to transportation from the scene of accident or illness to the nearest hospital, as opposed to local professional ambulance service which pays for all local services. It should be used only in those areas in which hospital facilities are not available and is in lieu of local professional ambulance service. (No additional premium required.)

3. Deductible

(a) *Maximum*.—If the deductible for the plan includes "1% of earnings" the maximum deductible may be limited to \$300 provided not more than 5% of the employees earn over \$30,000. (No additional premium required.)

(b) *Minimum*.—A flat \$50 deductible may be substituted for \$50 or "1% of earnings". In such cases it is recommended that the employer pay 40% of the premium for Major Medical but this liberalization may be made even if the employer contributes only the standard 25% minimum. (Additional premium is required.)

E. NON-STANDARD PROVISIONS WHICH THE OFFICE WILL CONSIDER

1. *Psychiatric care*

The standard provision requires that the employee bear a larger share of the expenses for non-disabling psychiatric care. This means that, if the employee is not totally disabled or if a dependent is not confined to a hospital, benefits will be limited to 50% of covered medical expenses. Some employers have requested a further limitation under non-disabling psychiatric care. Generally, complete exclusion of such care is not recommended and as an alternative, the covered expenses may be limited to a fixed amount such as \$20 per visit, with or without a further limitation of either 50 visits a year or a specified dollar amount such as \$500 annually.

DISTILLERY

1. Is this a first-class distillery with favorable working conditions? Give facts to support opinion.
2. Is the distillery a modern up-to-date plant?
3. What is the general opinion as to the type of personnel employed?
4. Are general living conditions of the employees at least as good as average?

CLERGY

1. *Information needed:*

(a) Employer-employee relationship—who can act as employer and by what authority? There must exist a relationship similar to that in industry whereby an individual or a governing body controls the appointment or transfer, discontinuance and earnings of the clergymen and others to be insured. Home Office needs a copy of the canons or constitution and by-laws of the regional body such as the Diocese, Conference, Synod, etc.

(b) Administration facilities—it must be established that the governing body maintains a central headquarters having adequate facilities and personnel for the administration of the Plan. For example, claims must be certified by the "Employer" and this is particularly important if Disability coverages are included. Also, the "Employer" must remit premiums and, if the Plan is contributory, collect the necessary contributions.

(c) If Accident and Sickness is to be included, to what extent are earnings lost in case of disability?

2. *Underwriting notes*

(a) *Ages*.—Generally, the ages of clergymen are higher than for industry in general because of the absence of the turnover generally experienced in industry.

(b) *Life Insurance*.—In making cost quotations the predominance of older people and the necessity of having a reduction formula—if the schedule has amounts in excess of \$1,000—for employees age 65 and over should be taken into consideration.

(c) *Hospital, Surgical and Physicians' Attendance Insurance*.—Special problem as to rates.

(d) *Medical Expense and all types of Major Medical Plans*.—These coverages should not be discussed in the early stages of any negotiations without Home Office approval.

(e) *Occupational Coverage*.—All Personnel Disability coverages offered will include both occupational as well as non-occupational benefits because of the difficulty of distinguishing between occupational and non-occupational injury or sicknesses for a clergyman. Only non-occupational coverage is available for dependents.

GROUP SALES REPRESENTATIVES

CLAIMS—REASONABLE AND CUSTOMARY FEES

The attached material distributed to Group Claim Consultants should be carefully reviewed by all field representatives for their guidance in discussing payment of claims on a Reasonable and Customary basis with prospects and policyholders.

It is suggested that those who have received the booklet "New Developments in Medical-Surgical Programs" in connection with the discussion of that "White Paper" should make this memorandum a part of that material for future reference.

H. O. HOYT, Jr.,

MARCH 24, 1970.

To: *All Group Claim Consultants.*

Attached is an extract from a letter recently written by John Meyer, Assistant General Counsel in our Law Division, on the subject of physicians' "reasonable and customary" fees. We are bringing this to your attention because we believe it states the Company's position on a sensitive subject in a very clear and understandable fashion. It is important that you be fully aware of the dangers inherent in "negotiating a fee" with a physician, and that you refrain from going beyond the limitations set forth in Mr. Meyer's letter.

M. W. GALBRAITH,
Vice-President-Group Claims
Group Insurance & Pensions.

"Re: Payment of claims which are payable on a reasonable and customary basis.

In such endeavor, it is maintained that while the insurance company has the right to secure information before paying a claim, *it does not have the right to negotiate a fee* with the claimant's physician and that the negotiation of a fee involves the following four points which can serve as the basis for legal action against the insurer and the employer by the employee:

I. Slander.

II. Invasion of privacy.

III. Tortious interference with the contract rights of third parties.

IV. Failure to "spell out" to the employee that administrative practice goes beyond "securing information."

The employee's group certificate makes provision for payment of "physicians' Services Benefits" and states:

"If any of the Services, as defined below, are rendered to you or a Dependant by a physician for diagnosis or treatment of non-occupational sickness or injury while such person is covered under this plan, benefits will be paid, subject to the terms, limitations and exclusions of the Plan, in an amount equal to the fee charged for such service rendered to the extent such fee is reasonable and is the customary fee of the physician for such service, as determined by the Insurance Company.

The Insurance Company will determine what constitutes a reasonable and customary fee by taking into consideration:

(a) the usual fee which the individual physician most frequently charges to the majority of his patients for a similar service or medical procedure:

(b) the fees which fall within the customary range of fees charged in a locality by most physicians of similar training and experience for the performance of a similar service or medical procedure;

(c) unusual circumstances or medical complications requiring additional time, skill and experience in connection with a particular service or medical procedure.

The provisions set forth in items (a), (b), and (c) of the preceding paragraph are designed to recognize that there will be differences in physicians' fees because of such factors as geographical locality, skill of the physician, and complexity of the service performed.

At the outset it should be understood that Metropolitan's claim administration is not authorized to negotiate a physician's fee or the amount of any fee agreed upon by the patient and his physician. *It does, however, have the undoubted right to pay only such sum which its contract obligates it to pay* as a reasonable and customary charge, and in fulfillment of such obligation it may properly attempt to obtain agreement as to the physician's reasonable and customary fee in the light of the policy provisions. This, however, may discharge the insurer's obligation, *but it leaves unaffected any obligation of the patient.* This is quite apparent from the fact that the physician may wish to deal only with his patient in the matter of payment of fees, in which case the insurer's payment is made directly to the insured individual, but on the basis of the contract promise.

Correctly administered as aforesaid, there is involved no slander, invasion of privacy or tortious interference with contract rights of third parties. In the fulfillment of its own contract, there may not be said to be an actionable tort as to a separate and distinct contract which remains unaffected by the fulfillment of the other.

With regard to a failure to spell out to an employee that administrative practice as to the operation of the "reasonable and customary" provision goes beyond securing information, I can say only that reasonable minds may reasonably differ as to a doctor's usual fee to a majority of his patients; the customary

range of fees charged in the locality by most physicians of similar training and whether or not circumstances or complications or skill and experience are a factor. It is accordingly inherent in the clause that in some cases where a difference of opinion exists that there should be communication in an amicable attempt to explore the differences and come to an agreement which will discharge the insurer's obligation in a mutually satisfactory manner. Indeed, a failure in this regard would undoubtedly be cited as an intolerable instance of insurance company highhandedness, in a problem requiring tact and understanding.

The creating and establishing of Medical Review Boards in various medical societies throughout the United States with authority to review charges of physicians with respect to reasonableness and whether the charges are customary, is an added indication of the propriety of an insurer's activity in fulfilling its contract obligations, and that this obligation extends beyond the mere securing of information.

COOPERATIVE ADMINISTRATION OF GROUP HEALTH INSURANCE PLANS

Hospital, Surgical, Major Medical—"The success of these policies will be seriously impaired or destroyed if improper usage tends to increase the cost of medical care." Isn't the burden here on the consumer, since the manual notes that the insurance company and the employer ". . . should be concerned primarily with those matters which directly affect the amount of benefits *allowable* under the plan?" and, that "Metropolitan would be open to valid criticism for any attempt to intrude in situations which do not have a direct bearing on the cost of insurance." In other words, would it be an intrusion for the insurance company to question costs to the patient which exceed allowable benefits?

Most claims under Group coverages providing reimbursement for medical care expenses do not require special consideration or handling, however some will present certain problems of a varied nature. The advent of Extended Medical Expense and Major Medical Expense policies as well as other plans based on the concept of "reasonable and customary" charges with their broad scope, liberal provisions, and the absence of inside limitations have enlarged somewhat the areas of potential abuse or misuse. The success of these policies will be seriously impaired or destroyed if improper usage tends to increase the cost of medical care in any significant degree. Education of employees, physicians, and hospitals as to the purposes of this type of insurance and the dangers of misuse is essential for proper functioning.

While the need for effective claim administration of Extended Medical Expense and Major Medical Expense policies and similar plans can be readily appreciated, it is a fact that the basic Hospital and Surgical contracts, which usually provide a fixed schedule of benefits, are also susceptible to overuse or misuse. The problems are generally the same with the exception that under the basic type coverages the use of unnecessarily expensive medical services sometimes places the burden on the patient rather than on the insurance plan. In general, we should be concerned primarily with those matters which directly affect the amount of benefits allowable under the plan. Metropolitan would be open to valid criticism for any attempt to intrude in situations which do not have a direct bearing on the cost of insurance. Physicians in particular resent any unwarranted interference in the traditional patient-physician relationship.

A. THE ROLE OF THE INSURANCE ADMINISTRATOR

The principal contributions which the Insurance Administrator can make toward a program of sound claim administration in cooperation with the Metropolitan are:

1. To familiarize employees, physicians, and hospitals with the provisions of the plan and enlist their cooperation in controlling medical costs and eliminating overutilization or misuse.

This is probably the most effective means of achieving satisfactory claim experience under an insurance plan. The informational programs for the several groups of persons who either participate in the plan or are affected by it should be on a continuing basis, because the membership of the group changes from time to time. Also, people tend to forget such matters and need to be reminded now and then. Regular and fairly frequent use should be made of employee publications, bulletin boards, and other media for communicating messages to employees about their rights and responsibilities under the insurance plan.

When a message might be of particular interest to physicians or hospital administrators in the community, copies could be sent to them with a personal letter from the Insurance Administrator or other official of the Company.

2. To detect any specific instances in which it is believed that unfair advantage has been taken of the Insurance Program and to alert the Metropolitan to the situation.

Individual cases by themselves may not be too significant. If, however, the Insurance Administrator keeps records of such cases, it may enable him to make comparisons and pinpoint primary sources of trouble. It may be found, for example, that an individual physician or group of physicians are contributing towards adverse claim experience or it may be demonstrated that the same is true of a particular hospital.

The Group Health Claims Division of the Metropolitan Life Insurance Company has the primary responsibility for the control of claim costs under the various Medical Expense coverages. To accomplish this, claims are evaluated very carefully on the basis of the medical information available and are subject to personal investigation if there is evidence that charges are unreasonable or medical treatment is unusual. Once again, however, the Insurance Administrator, because of his more intimate knowledge of local conditions, can be of great help to the Insurance Company. In particular his familiarity with and sources of information about physicians and hospitals can be very useful in identifying areas where claim abuses may exist.

Again, the implementation of an effective cost control program requires the closest cooperation between the Insurance Administrator and the Metropolitan. The Insurance Administrator can function most usefully by bringing these matters to Metropolitan's attention and by developing all pertinent information necessary for proper review and action by the latter.

3. To understand that the existence of duplicate health or medical expense insurance that results in overinsurance can have a very significant effect upon the cost of an insurance program and should be discouraged. Duplication of coverage, in most cases, is economically unsound because it removes all financial incentive on the part of the employee to hold his medical expenses down to the level of what is reasonable and necessary. It may be that the more expenses he incurs, the greater will be his financial gain.

Duplicate coverage that results in overinsurance is not popular with physicians or hospitals. They do not like to see anyone "make money" as a result of illness, and there may be a tendency on their part to increase the cost of medical services because of this fact.

B. CONSIDERATIONS COMMON TO BOTH BASIC AND EXTENDED COVERAGES

The Insurance Administrator should be familiar with basic considerations applicable to the various Medical Expense coverages. An understanding of these matters, together with knowledge of the general procedures followed by the Metropolitan in evaluating claims, will enable the Insurance Administrator to take an active part in working with Metropolitan towards more effective claim cost controls. The following points should be considered:

4. HIGH HOSPITAL CHARGES

Since hospital room-and-board benefits are generally subject to ceilings of one sort or another as specified by the plan, any problem concerning hospital charges is more apt to relate to those for ancillary services, which are sometimes difficult to evaluate. One of the best methods for evaluating such expenses is to compare charges from various hospitals against each other. Generally speaking, hospitals in the same area should have approximately the same rates for room and board as well as ancillary services. Charges from a particular hospital which are higher than those of other hospitals in the same locality should be cause for concern and should warrant inquiries on the part of the Insurance Administrator. There is, of course, the possibility that ancillary charges may be higher when a private room is used, and this should be considered when comparing charges on different claims.

If the employee received a bill or statement from the hospital and it is readily available, a detailed comparison with the charges listed by the hospital on the claim form should be made. If any material discrepancies are found, and the employee was not given an explanation of them, the hospital administrator should be contacted for an explanation.

5. DUPLICATION OF COVERAGE

In recent years the number of families with more than one employed member has increased considerably. As a result, members of the same household may be covered under more than one medical insurance plan. This has created a situation where an insured individual may receive more in benefits than the actual charges for medical care. Profits derived from over-insurance can hurt everyone concerned with getting good medical care at a reasonable cost.

When an individual can make a profit from his medical care insurance he is tempted to insist upon the type of service that will produce the greatest possible profit. He may want to (I) remain in the hospital after he has recovered, (II) make use of medical services or facilities that are not medically needed, or (III) enter the hospital for minor medical problems which could very well be treated at home or in the doctor's office. Any unnecessary use or overuse of medical care services tends to raise the cost of medical care for all individuals (not just those making a profit) and can also make it difficult for those needing prompt care to obtain it because of the excessive demand on medical facilities.

It is important to keep in mind that Group Insurance is intended to help pay for covered medical expenses when the unexpected need occurs. Its purpose is to protect employees from financial loss—not to provide a means of being reimbursed for more than the actual expenses incurred.

Most Metropolitan Medical Care coverages (both Basic and Major Medical) contain either a Non-duplication clause or a Coordination of Benefits provision. While there are important differences between the two, the major purpose of each is to prevent overinsurance and reduce the possibility of profit arising out of duplicate insurance coverage. Both the Non-duplication clause and the Coordination of Benefits provision effect a reduction in benefits ordinarily provided by the plan when the person on whose behalf claim is made is also covered under certain other types of insurance or prepayment plans.

Space is provided on the claim form for the employee to indicate the existence of other plans and the coverages provided. Metropolitan cannot consider payment of any claim in which this information is omitted.

STATEMENT TO THE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY OF THE COMMITTEE ON THE JUDICIARY OF THE UNITED STATES SENATE CONCERNING METROPOLITAN LIFE INSURANCE COMPANY AND MEDICAL INFORMATION BUREAU

This is in reply to that part of Senator Hart's letter of May 18, 1972, bearing on the Metropolitan's relations with the Medical Information Bureau (M.I.B.).

We use information obtained from the Medical Information Bureau (M.I.B.) as one adjunct to our process of underwriting individual life insurance and health insurance policies. Underwriting is the process of appraising the degree of risk involved in the particular case in order to determine the premium class for the policy being applied for, or to determine if a policy can be issued.

One of the basic fundamentals of the insurance business is its risk-spreading nature. In order for risk-spreading to work, the insurer must be in a position to judge the risks which it undertakes to insure; in short the insurer must have information as to the condition of health of its applicants. Unfortunately not all persons who apply for insurance are truthful. The M.I.B. exists because of the unfortunate fact that some applicants don't tell the truth. If there were no M.I.B., the mortality of our standard life insurance class and the amount of health insurance claims would undoubtedly increase. This would result in higher premiums for the great majority of honest people who apply for insurance.

Some specific facts follow with respect to Metropolitan's use of the M.I.B. for individual health insurance. In 1971, a typical year, Metropolitan received 145,000 applications for individual health insurance. Of these 145,000 applications, M.I.B. yielded significant unadmitted information on approximately 3,000 applications (2% of the total). Investigation was made by Metropolitan on all 3,000 applications. As a result of our investigation, Metropolitan was able to offer contracts to 1,200 of these applicants, and declined to offer a contract in 1,800 cases (1.2% of the total number of applications). In addition to the 1,800 cases declined because of information developed as a result of our being alerted by an M.I.B. report, Metropolitan declined some additional cases because of knowledge developed through our usual sources of medical information.

We regard all medical and related information made available to us (whether on applications for insurance or obtained from physicians and hospitals on

specific authorization of the applicants) as confidential and we maintain precautions to guard its confidentiality. Such information is used by the physicians on our staff in a professional way in appraising the risks we seek to insure. Our relations with the M.I.B. is a direct responsibility of our Chief Medical Director.

The principal sources of medical information we report to the M.I.B. on an individual are: i) Answers he gives on the application for insurance or in connection with a policy claim, ii) Information obtained from a medical examination made as a part of the application for insurance, iii) Information provided by his physician or his hospital upon authorization furnished by the individual in connection with his application for insurance.

We are indicating below answers to the 17 detailed questions, lettered (a) to (q), contained in your letter.

We would report information on medical impairments to the M.I.B. from the following sources if they were made available for our review by authorization of the applicant.

- a. Insurance company medical examinations for life insurance applicants.
- b. Insurance company medical examinations for health and accident insurance applicants.
- c. Medical records of attending physicians.
- d. Medical records of hospitals.
- e. U.S. Veterans Administration medical records.

We do not ordinarily have information available from the following types of sources and therefore do not report it to the M.I.B. Occasionally it might be voluntarily furnished to us by a physician, upon authorization by the applicant, such as in the case of (h) Independent laboratory records; and in this event we would report it to the M.I.B.

- f. U.S. Department of Defense medical records.
- g. Other Federal, state, county and municipal medical record sources.
- h. Independent laboratory records.
- i. Pharmacy records.
- j. Information from other insurance companies.
- k. Records of manufacturers of medical appliances and devices.
- l. Records of executive examination agencies.
- m. Records of voluntary health agencies.
- n. Blood bank records.
- o. Voluntary alcoholic assistance agencies' records.
- p. Voluntary drug assistance agencies' records.
- q. Other sources. Please specify each.

The last paragraph on Page 2 of your letter raises certain questions regarding charges for M.I.B. The portion of our charges of the automation development by M.I.B.'s servicing agent, The Recording and Statistical Corporation (branch of Sperry Rand Corporation), amounted to \$13,671 in 1970 and \$13,001 in 1971. These costs are included in the payments to Recording and Statistical Corporation, the servicing agent, as shown in Metropolitan's Schedule G of \$64,246.34 for 1970 and \$183,307.42 for 1971. These charges are also reflected in Item 4.3 of Exhibit 5 of the Annual Statements, allocated approximately 90% to individual Life insurance and 10% to individual Health insurance.

The differences in costs between 1970 and 1971 reflect a change in the procedure of obtaining M.I.B. information. In 1970, M.I.B. information was handled on a manual basis with Metropolitan personnel performing certain clerical work. In 1971, the system was converted to the computerized basis, with information being handled by the Recording and Statistical Corporation.

Our dues to M.I.B. amounted to \$1,100 for 1970 and \$1,100 for 1971.

GROUP INSURANCE MANUAL

"Other Coverages Required" with group hospitalization.

E. OTHER COVERAGES REQUIRED

May be issued without other coverages (but see note below re: Texas and Louisiana cases). It is preferable to include Hospital Expense Insurance in a package including at least Life or Accident and Sickness insurance and Surgical Operation insurance.

Note: Requests for Hospital Expense Insurance where Metropolitan Group Life or Accident and Sickness insurance is not in force or written concurrently in

Texas or Louisiana are to be referred to the Home Office. An outline of the information required for consideration is on file in the interested Regional Office.

F. UNDERWRITING PRINCIPLES

It is important to avoid both under-insurance and over-insurance and it is, therefore, essential to be sure that benefits offered are consistent with local hospital charges and that such benefits do not supplement an existing plan administered either by an insurance company, a self-insurance arrangement or Blue Cross. Uniform amounts of Daily Benefit for all employees and dependents is desirable.

Plans may not be written which provide Reimbursement basis for some employees and a Fixed Daily Benefit basis for others; nor may the plan for dependent coverage be different than that for employees. However, because of the cost factor which in turn could affect employer-employee interest in the Plan, the Daily Benefit for dependents may be lower than for employees.

In no event may the dependent Daily Benefit for any employee exceed his personal benefit.

G. OLDER EMPLOYEES

Plans for Groups with 15% or more of employees age 60 and over must be given special consideration. See "Rates—Gen'l Info." Section.

H. OLDER PLANS

In early years in this field, the Metropolitan sold Hospital Plans which differ from those currently offered. e.g., maximum Special Services of 5 times the Daily Benefit or exclusion of employees age 70 or over. There are still a few such plans in force and if one of them is to be revised, every effort should be made to change to up-to-date policy provisions.

I. RETIRED EMPLOYEES

Generally, Hospital Expense Coverage is cancelled when an employee retires. However, the employer may amend the Policy to provide for continuance of coverage after retirement. For procedures see Insurance For Retired Employees in Und. Gen'l Section.

J. CONVERSION PRIVILEGE

The employer may arrange to include a provision in the Policy entitling the employee to convert hospital coverage to an individual policy upon termination of employment.

[Excerpt from Health Rate Book—Metropolitan Life Insurance Co. (Personal Health Insurance—Plan Descriptions and Underwriting Rules)]

OCCUPATIONAL RATINGS FOR PERSONAL HEALTH INSURANCE

OCCUPATION AND AVIATION RATINGS FOR PERSONAL HEALTH INSURANCE

Needless correspondence, loss of time, and even failure to place a policy will be avoided by strict adherence to the following plan of describing the occupation. You should state the industry, the department of the worker, the particular process engaged in, the trade title of the occupation, and the exact duties of the applicant. Whenever the name of the firm does not indicate the product manufactured, give full details. The following examples will show what is required.

EXAMPLES

Driller

Industry : Building and construction.

Department : Tunnel construction.

Particular Process or Duties : Drilling rock; not working under compressed air.

Glaze mixer

Industry : Pottery.

Department : Glaze.

Particular Process : Mixes lead with other ingredients to prepare "slip" for dipping purposes.

Foreman

Industry : Patent leather.

Department : Finishing.

Particular Process or Duties : Supervising 10 men engaged in tacking skins on frames and coating with paints and colors.

Note:—The better rating given to foremen as compared with skilled workers in certain industries applies to supervising foremen only. Working foremen are rated the same as skilled workers. (

To help the Agent further in describing the occupation, a list of questions has been prepared for the industries and occupations in which it has been most often necessary to delay issuance of a policy pending receipt of further information. For those occupations or industries shown on the following pages, it will be necessary to answer all the pertinent questions listed. If there is not sufficient space in the application for entering full details of the occupation, attach a letter giving full particulars.

QUESTIONS TO BE ANSWERED BY APPLICANTS EMPLOYED IN SPECIFIED INDUSTRIES
AND OCCUPATIONS

1. Actors and showmen

1. Where is the applicant usually employed—radio studio, television studio, moving picture studio, night club, etc.?

2. What is the nature of the act?

3. Does it involve acrobatic or stunt work? Height at which performed?

2. Building contractors, architects, civil engineers

1. For what kind of construction work does this company contract?

Note—If any of the following kinds of work are done, specify which : Bridge, wharf, railroad, road or street, structural iron, tunnel, compressed air, underground mining, roofing or cornice setting. If the company does any of these, give full particulars as to the amount of time spent by the applicant on such work and his exact duties in connection therewith.

2. How many men does he employ or supervise?

3. Does he do office work only, having foremen or a superintendent to actively supervise construction?

4. Does he inspect work in course of construction? If so, how frequently?

5. Does he personally supervise the construction work? How much of his time is thus spent?

6. Does he personally do any of the actual work? If so, how frequently?

3. Chauffeurs and drivers

1. Is he a driver salesman selling to homes?

2. Specify type of vehicle driven and the kind of material transported.

4. Chemicals and explosives

1. What chemicals are manufactured in the plant in which the applicant is employed? In his department?

2. What are the applicant's exact duties?

3. If explosives are manufactured or stored in the plant, state how frequently the applicant goes to plant process or storage buildings and the average time spent there weekly.

5. Chemists, chemical engineers, and laboratory assistants (technicians)

1. Is he a graduate chemist or a chemical engineer?

2. Does he do laboratory work only?

3. Are his duties supervisory only or does he take active charge of a manufacturing process?

4. What chemicals are manufactured by the company by which he is employed?

5. If applicant is employed by a company manufacturing explosives or if he takes active charge of a manufacturing process, send answers to Chemicals and Explosives questions also.

6. Electrical industry

1. Where is applicant called upon to work—laboratory, power plant, factory or dwelling, or construction and maintenance along the line?

2. What electrical apparatus does the applicant tend, inspect, etc.? What are his duties in connection there with?

3. Does the applicant do repairing? What does he repair?
4. Does the applicant do testing? What does he test? How frequently?
5. Does the applicant climb poles? How frequently?
6. Does the applicant work in conduits?

7. *Farmers*

1. State kind of farm (stock, dairy, etc.) and whether the applicant is a farm owner, renter, manager, foreman, or laborer.
2. Is farming his only occupation throughout the year?
 - (a) What other work does he do?
 - (b) Specify how much of his time is spent in farming.
3. What is the approximate acreage of the farm he operates?

8. *Finishing operations—Metal products*

State which the applicant does: grinding sandblasting, sanding, metal chipping, waxing, or rubbing down. What portion of his time is spent on each?

9. *Fishermen*

1. Is the applicant a captain, engineer, or other officer? Specify. State the number in crew.
2. Is fishing his only occupation throughout the year? What other work does he do?
3. How much of his time is spent in fishing?
4. State in what waters he fishes—Grand Banks, other ocean, Great Lakes, or inland waters.
5. State the principal kind of fish caught—lobster, shrimp, tuna, etc.
6. Does he return to shore every day?
7. State the length, gross tonnage, and type of vessel used—trawler, dragger, or other power vessel.

10. *Foremen*

1. How many men are directly under the applicant's supervision? What are their duties?
2. Are his duties entirely supervisory? If not, give nature of and time spent on other work.

11. *Grinding and polishing*

1. Specify whether the process is (a) an automatic process, in which the article is held in place and ground or polished by entirely mechanical means, or (b) a hand process in which either the article or the abrasive wheel is controlled manually. If a hand process specify type of wheel (carborundum, composition, cloth, leather, sandstone, etc.)

12. *Machinists*

1. What machines does the applicant operate?
2. Does he do more than a small amount of grinding, incidental to his regular work? If he does, state how much of his time is so spent and answer Question 11.
3. Does the applicant do millwright work, installing and maintaining machinery, shafting, etc.? If he does, how much of his time is so spent?

13. *Marine*

1. What is the applicant's rank or rating—captain, purser, engineer, oiler, seaman, etc.?
2. On what type of vessel is the applicant employed—passenger ship, general cargo vessel, tanker, tug boat, car ferry, sailing vessel, barge, lighter etc.?
3. If a passenger ship state name gross tonnage and number of passengers normally carried.
4. Is the vessel in ocean, coastal, Gulf, or Great Lakes trade, or is it only in inland water trade (rivers, sounds, bays, lakes other than Great Lakes)?

14. *Mining*

1. What minerals are produced? If coal state whether anthracite or bituminous.
2. State what type of mine it is—underground, open pit, placer or hydraulic.
3. Specify the applicant's exact duties and where performed.
4. Has he any duties in the mine?
5. State how many times per month, on the average, the applicant went into mines in the past year and the average number of hours spent underground monthly.

15. Monument shops

1. How many men does the applicant employ or supervise?
2. What are his exact duties?
3. How much of his time is spent in carving, lettering, or sandblasting? If none, how recently was he so engaged and over what period of time?

16. Oil—Geophysical exploration

1. Specify the geophysical method used—seismic, gravitational, etc.
2. What are the applicant's exact duties?
3. Does he transport, handle, or detonate explosives?
4. Has the applicant's occupation required him, or may it require him, to work outside of continental United States or Canada? If so, where and for how long?

17. Shipbuilding and dry docks

1. Specify the applicant's exact duties.
2. State where he works—on the hull, deck, or superstructure, in cabins or interior finishing, or in shop. If in a shop, state kind—boiler, machine, etc.
3. What are the types and sizes of vessels built or repaired?

OCCUPATIONAL RATINGS LIST—PERSONAL HEALTH INSURANCE

It is not possible to include every occupation in the list, so some listings and general descriptions of the various classifications are given below. *The alphabetical list of occupations should, however, always be consulted*, keeping in mind that if the specific title is not shown, the occupation, or one very similar to it may be listed under another title.

Loss-of-time policies

Form A.H. 9-67.

Men—AAAA, AAA, AA—All Benefits available but first day accident or lifetime accident not issued as Class AA7, and Benefit E issued at Class AA only if meeting height and weight requirements for Preferred Life.

A—If there is no dagger (†) after the classification, occupations considered for Benefit A with 5 year maximum benefit period only; Benefit B without first-day accident; Benefit C only with Benefit A with or without F; Benefits E and G and lifetime accident not issued at this class.

Women—AAAA, AAA—All benefits except first day accident. AA—Benefit C only or C and F.

Form A.H. 8-65.

Men—AAAA, AAA, AA—(A in certain non-seasonal occupations. Not available if there is a dagger (†) after the classification.)

Forms A.H. 7-60, A.H. 7P-60, A.H. 7W-60.

Men and Women—AAAA, AAA, AA.

Men only—A, AE.

Hospital, surgical, and medical expense policies

All the occupations classified A, A†, AE, or better, as well as those classified "H & S," are eligible for these forms.

Class

AAAA—This class is intended for high grade salaried office workers such as officers of corporations, and persons employed in business offices, banks and similar organizations. Also included would be such persons as accountants, attorneys, and auditors. This class may also include certain manufacturers whose duties are entirely confined to office work with no supervision of any manufacturing process.

AAA—The following generally would be eligible for this class: Insurance agents, clergymen, dentists, physicians, brokers and outside salesmen who do not deliver or handle merchandise, clothing manufacturers, postmasters and postal clerks (not handling parcel post). Also included would be manufacturers of soft goods, such as textiles, whose duties include superintending.

AA—The following generally would be eligible for this class: Merchants and clerks dealing in hardware or automobile supplies, servicemen who use hand tools on the premises of the customer, and manufacturers of hard goods, such as metal products and wood products, whose duties include superintending. Foremen who superintend but who do not have manual duties, as well as driver

salesmen selling to homes (bakery, dairy, etc.), will be considered, except that in this and other occupations designated AA7, first day accident or lifetime accident will not be issued.

A—The following generally would be eligible for this class: Retail salesmen and delivery or servicemen who do not qualify for AA, and most skilled and semi-skilled workers classified Standard for Life insurance.

Issue of Forms A.H. 7-60 and A.H. 7P-60 with a maximum weekly indemnity of \$120 will be considered for this class. Also issue up to a maximum, monthly indemnity of \$500 (\$600 for Term to 65) under Form A.H. 8-65 and all benefits of Form A.H. 9-67, except E, G, first-day accident and lifetime accident, will be considered up to \$600 monthly indemnity with a 5 year maximum indemnity period if there is no dagger (†) after the classification; and if the occupation is not subject to seasonal fluctuations or risk of layoff, such as might occur in the building trades or in clothing manufacture.

AE—This class includes occupations involving considerable risk of occupational injuries. The following are the principal occupations in this class: Roofers, outside painters and others working at heights, brick and stone masons, taxicab owner-drivers, plasterers and stucco workers.

Form A.H. 8-65 will not be issued to this class. Issue of Forms A.H. 7-60 and A.H. 7P-60 will be considered at Class A rates subject to a rider excluding coverage for occupational injury, or, if the applicant prefers, the rider will be omitted subject to 10% premium increase over the premium for Class A.

H. & S.—Occupations so designated are eligible only for Hospital, Surgical and Medical Expense policies.

U—Occupations so designated are unacceptable for any form of Personal Health coverage, including Hospital, Surgical and Medical Expense policies.

7—This symbol means that lifetime accident or first-day accident coverage will not be issued. In other words, an accident elimination period of at least 7 days is required with no extension beyond the normal maximum indemnity period.

—This symbol means that if the applicant is the owner or manager and if there are at least six full-time employees the next better class will be considered. In the case of AA7 or A*, consideration for the next better class will not extend to consideration for a policy with first-day accident or life-time accident coverage. In the case of AA*, consideration at AAA will be given for any policy form.

†—This symbol means that, for Loss of Time policies, only Forms A.H. 7-60, A.H. 7P-60 will be considered for Class A.

Occupation or Industry

*Health
ins. class*

Abrasive Industry :

Manufacture—all departments (Alundum, carborundum, diatomaceous earth, emery, kieselguhr, pumice, quartz, sand and tripoli)	
Foreman	AA7
Skilled workers.....	A
Laborers	U
Abrasive products (Grinding wheels, sand and emery paper, etc.)	
Clay department	
Foremen	AA7
Skilled workers.....	A
Other departments	
Foremen	AA7
Kiln firemen, setters, drawers.....	A
Other skilled workers.....	A
Laborers, all departments.....	U

Acetylene Gas Manufacture :

Superintendents, chemists, laboratory assistants (technicians)—not engaged in process work.....	
Foremen	AA7
Skilled process workers.....	A
Plumbers, pipefitters, steamfitters.....	A†
Cleaners of stills, tanks, etc.....	U
Rackmen, truckers (hand), and other laborers.....	U

Occupation or Industry—Continued

Health
ins. class

Acid Manufacture (all acids) :

Superintendents, chemists, laboratory assistants (technicians)— not engaged in process work	AAA
Foremen	AA7
Skilled process workers	A
Lead burners	H & S
Plumbers, pipefitters, steamfitters	A†
Cleaners of stills, tanks, etc.	U
Laborers	U

Actors and Actresses. See Amusements and Sports—General

Adding and Office Machine Repairers :

Not in shop	AA
In shop	A

Aerial Services and Airport Employees. See Aviation

Agents—Real Estate. AAA

Air Transport Company Employees. See Aviation

Airplane Manufacture. See Aviation

Alcohol Manufacture (Excluding liquor distilleries, for which see under Liquor and Allied Trade) :

Fermentation, destructive distillation, and synthetic (pressure) processes	
Superintendents, chemists, laboratory assistants (technicians) not engaged in process work	AAA
Foremen	AA7
Still tenders, testers, kiln tenders, mixers, and other skilled workers	A
Cleaners of stills, tanks, etc.	U
Laborers	U

Akali Manufacture :

Caustic soda and potash, bleaching powder, soda ash, chlorine

Superintendents, chemists, laboratory assistants (technicians) not engaged in process work	AAA
Foremen	AA7
Cell operators, evaporator men, and other skilled process workers	A
Cleaners of stills, tanks, etc.	U
Laborers	U

Aluminum Mills and Foundries. See Metal Industries

Ambulance Drivers. A†

Ammonia Manufacture (Including cyanamid and synthetic or electro-chemical processes) :

Superintendents, chemists, laboratory assistants (technicians) not process work	AAA
Foremen	AA7
Catalyst operators, scrubber operators, and other skilled process workers	A
Laborers	U

Amusements and Sports :

1. General

Acrobats and moving picture actors doing acrobatic work :

On ground	H & S
Off ground	U
Actors and actresses, best grade only	H & S
Motorcycle and automobile racing—drivers and mechanics	U

2. Amusement Machines (Legally operated)

Slot (gaming) machines	U
Music, pinball, and similar machines	
Wholesalers and jobbers only	
Owners, salesmen	A
Retail distribution and service	
Owners, managers	
Office duties only	AA
Sales and service duties	A†
Music machines only	H & S
Other	H & S

Occupation or Industry—Continued

Health
ins. class

Salesmen, servicemen, and collectors	
Music machines only-----	A†
Other-----	H & S
3. Athletes, Professional	
Baseball players-----	H & S
Bicycle riders:	
Motorcycle or motor-paced racing-----	U
Others-----	U
Football and hockey players-----	U
Prizefighters and wrestlers, best grade only-----	U
4. Bowling Alleys, Billiard and Pool Rooms, Dance Halls, and Skating	
Rinks	
Beer, wine or liquor sold-----	See Liquor and Allied Trades
No beer, wine or liquor sold	
Proprietors, managers:	
Bowling alleys-----	AA7*
Others-----	A*
Cashiers:	
Bowling alleys-----	AA7*
Others-----	A*
Attendants-----	H & S
Porters and janitors-----	H & S
5. Horse Racing:	
Accountants, cashers, and clerks-----	AA
Jockeys and exercise boys; trainers, best grade-----	U
Stablemen-----	H & S
Starters-----	H & S
Trotting horse drivers (professional)-----	U
6. Motion Picture Cameramen (No Stuntwork) and Technicians-----	AAA
7. Musicians:	
Concert and symphony-----	AAA
Dance orchestra and others, best grade-----	A
8. Theaters:	
Proprietors, managers, executives	
Motion pictures-----	AAA
Stage shows primarily, best grade-----	AAA
Motion picture machine operators-----	AA7
Ticket collectors and ushers-----	AA7
Annealers (Metal mills)-----	A†
Apiarists-----	See Farmers
Apprentices-----	Rate as skilled workers in particulars trade or industry
Office duties and inspection only-----	AAAA
Supervising construction:	
Caissons, tunnels, docks, high structures, etc-----	H & S
Non-hazardous-----	AAA
Army-----	See Military Services
Arsenals-----	See Explosives Industry
Artificial Leather or Pyroxylin Plastic-Coated Material Manufacture:	
Superintendents, chemists, and laboratory assistants (technicians) not engaged in process work-----	AAA
Foremen-----	AA7
Skilled process workers-----	A
Plumbers, pipefitters, steamfitters-----	A†
Laborers-----	U
Artificial Silk (Rayon) and Cellophane Manufacture; Nylon—See Nylon:	
Superintendents, chemists, and laboratory assistants (technicians) not engaged in process work-----	AAA
Foremen-----	AA7
Skilled process workers-----	A
Plumbers, pipefitters, steamfitters-----	A†
Laborers-----	U

Occupation or Industry—Continued

Health
ins. class

Asbestos Industry:	
Mining, quarrying, and ore reduction-----	See Mining Industry
Products manufacture—millboard, shingles, siding, pipe covering, brake lining, textile products, etc.	
Superintendents and managers-----	AAA
Foremen-----	AA7
Beaters, wet machine operators, braiders, carders, mixers, spoolers, hydraulic pressmen, and similar skilled workers.	H & S
Openers, pickers, cleaners, chaser mill operators, fiberizers, powder makers, screeners, laborers-----	U
Asphalt Refining:	
Foremen-----	AA7
Stillmen, inspectors, pumpmen, and other skilled workers-----	A
Laborers-----	U
Asphalt Roofing Manufacture-----	See Roofing Manufacture
Assayers-----	See Chemists
Asylums-----	See Hospitals
Athletic Instructors—Schools and Colleges-----	AA7
Auto Body Repair and Paint Shops:	
Owners-----	A*
Employees-----	H & S
Automobile Manufacture:	
Steel mill and foundry-----	See Metal Industries
Stamping, assembling, and trimming	
Foremen-----	AA
Pressmen, assemblers, etc-----	A
Painters and sandpaperers-----	A
Body finishers-----	A
Shop testers-----	A†
Road and proving ground testers-----	H & S
Laborers-----	U
Automobile Sales:	
Dealers and sales managers-----	AA*
Salesmen-----	AA7
Automotive Service—Garages, Filling Stations, Parking Lots, and Car Laundries:	
Proprietors and managers, superintending only-----	A*
Other proprietors and managers-----	A
Mechanics, attendants, body repairers-----	H & S
Car washers and laborers-----	U

Classification

1. Passengers flying on United States and Canadian Scheduled Airlines §-----	See Occ.
2. Passengers—Other Flying-----	--
3. Pilots—Civil Aviation:	
Flying for United States and Canadian scheduled airlines in pas- senger service §-----	H & S
Flying for European scheduled airlines in passenger service §--	U
Flying for United States or Canadian airlines in non-scheduled passenger service or in scheduled or non-scheduled freight car- rier service-----	H & S
Private pilots:	
Experienced, age 27 or over, 125 hours flight or less per year--	--
Others-----	--
Professional pilots of employer-owned planes (passenger or freight service):	
Experienced, age 27 or over, 200 hours flight or less per year--	H & S
Others-----	H & S

§U.S. scheduled airlines have been so certificated by the Civil Aeronautics Board for service over regularly established routes and scheduled airlines of other countries which, in the opinion of the Company, operate under comparable conditions.

Occupation or Industry—Continued

Health
ins. class

Pilots engaged in crop control:

Fixed wing	U
Rotary wing	U
Testing of new types of aircraft and experimental flying.....	U
Other pilots including student pilots.....	U

Pilots—Military and Naval Aviation:

Operational duty:

Military Airlift Command (United States) or Military Air Transport Squadrons (Canada):	
Transport planes—personnel or cargo.....	U
Others	U
Other than Military Airlift Command (United States) or Military Air Transport Squadrons (Canada):	
Fighters and attack bombers.....	U
Other multi-engine bombers.....	U
Helicopters	U
Troop or cargo transports; refueling tankers.....	U
Patrol (including antisubmarine patrol), photo and weather reconnaissance:	
Single-engine planes	U
Multi-engine planes	U
Army light liaison planes, fixed wing.....	U

Staff duty (primarily), flying for proficiency only:

Age 40 or over—all planes.....	U
Ages 30-39:	
Transports—personnel and cargo.....	U
Other planes	U
Ages under 30.....	Rate as operational duty

Training:

Air Force and Navy:	
Cadet and student pilots.....	U
Rated pilots in training.....	U
Instructors	U

Army—student and instructors:

Light planes	U
Helicopters	U

Former Pilots, Former Student Pilots:

Under age 30, has flown as pilot or has held student permit within 5 years.....	See Occ.
Age 30 or over, has flown as pilot or has held student permit within 2 years.....	See Occ.
All others, with no indication of renewed interest in aviation	See Occ.

Non-Pilot Flyers—Military and Naval Aviation:

Crew Members:

Military Airlift Command and Military Air Transport Squadrons (Canada):	
Transports—personnel or cargo; refueling tankers....	U
Others	U
Other than Military Airlift Command and Military Air Transport Squadrons (Canada):	
Fighters and attack bombers	U
Other multi-engine bombers; patrol planes.....	U
Helicopters; single-engine planes.....	U
Transports—personnel or cargo; refueling tankers....	U
Flight Surgeons.....	U
Paratroopers and airborne troops.....	U

Scheduled Air Transport Company Non-Pilot Employees:

Aircraft crew, including flight engineers.....	--
Airport and field service personnel, field managers, engineers, mechanics, radio technicians, service men, etc., having flight duties in connection with the observation, testing, etc. of aircraft or equipment.....	H & S

Occupation or Industry—Continued

Health
ins. class

Employees flying on scheduled airlines as a matter of transportation only-----	See Occ.
Employees doing no flying-----	See Occ.
8. Aerial Services and Airports: Non-Pilot Employees:	
Aircraft crew, including flight engineers-----	--
Airport and field service personnel having flight duties in connection with the observation, testing, etc. of aircraft or equipment-----	H & S
Others flying in the course of employment-----	See
Employees doing no flying-----	Occ.
9. Airplane Manufacture: Non-Pilot Employees	
Flying field personnel having flight duties in connection with the observation, testing, etc. of aircraft or equipment-----	H & S
Others flying in the course of employment-----	See
Employees doing no flying-----	Occ.
Awning Hangers-----	A†
Awning Makers-----	A
Bacteriologists:	
Routine laboratory work-----	AAA
Others-----	--
Bakelite and Other Non-Pyroxylin Plastics-----	See Plastics Industry
Bakeries:	
Wholesale bakeries:	
Bakers, dough mixers, packers, and other skilled workers--	A
Laborers-----	U
Bakery shops:	
Owners:	
Best grade—supervisory duties-----	AA*
Superintending, including counter duties-----	AA*
Delivering-----	AA7
Baking-----	A
Bakers and skilled helpers-----	A
Barber Shops:	
Proprietors and managers-----	A*
Employees-----	A
Bargemen-----	See Marine Industry
Bartenders-----	H & S
Bath Attendants—Hot Baths-----	H & S
Battery Manufacture-----	See Electrical Industry
Battery Service Station Workers-----	A
Beauty Parlors:	
Proprietors and managers-----	A*
Employees-----	A
Bell Boy-----	H & S
Beverage Industry (Non-Alcoholic):	
Proprietors:	
Superintending only-----	AAA
Others:	
No delivering-----	A
Delivering-----	A†
Foremen; skilled workers-----	A
Laborers-----	U
Bill Posters-----	A†
Billard Parlors-----	
Blacksmiths, generally:	
Horseshoes-----	A†
Machine shop-----	A
Mines-----	See mining industry

Occupation or Industry—Continued

Health
ins. class

Blasters and Shooters :	
Building and construction—general.....	H & S
Mines :	
Surface and open pit ; underground potash and salt.....	H & S
Others	
Oil fields and wells :	
Geophysical exploration—seismic method.....	U
Others	U
Quarries	H & S
	AA7
	A
	U
Bleaching Powder Manufacture.....	
Boat Building.....	
Boiler Inspectors (Government or insurance company) :	
Land boilers.....	AAA
Marine boilers.....	AA
Boiler Washers and Cleaners.....	U
Boilermaking :	
Foremen	AA7
Inspectors, layers-out.....	AA7
Boilermakers and helpers (apprentices).....	A†
Boilermakers' laborers and helpers (laborers).....	U
Bookbinders	AA7
Bootblacks and Hat Cleaning Establishments :	
Proprietors	H & S
Bootblacks	U
Porters	U
Other employees.....	U
Bottling Plants :	
Non-alcoholic beverages.....	See Beverage Industry (Non-Alcoholic)
Beer, wine, liquor.....	See Liquor and Allied Trades
Bowling Alleys.....	See Amusements and Sports
Brass Mills and Foundries.....	See Metal Industries
Breweries	See Liquor and Allied Trades
Brick Manufacture :	
Glazed brick workers.....	See Potteries—glazers, glassmakers
Foremen	AA7
Skilled workers.....	A†
Laborers	U
Bricklayers and Masons :	
Apprentices	Rate as skilled tradesmen
Helpers (not apprentices).....	Rate as laborers in particular industry
Building and construction :	
General construction.....	AE
Bridge and structural iron and steel.....	U
Caisson workers.....	U
Marine—docks, etc.....	H & S
Smokestack and chimney.....	H & S
Tunnel and shaft :	
In compressed air.....	U
Not in compressed air :	
Finishing operations.....	A†
Others	U
Coke ovens ; glass (relining furnaces).....	AE
Explosives (except small arms ammunition).....	U
Metal mills (iron and steel, brass, etc.).....	See Metal Industries
Mines	See Mining Industry
Railroads (bridges-and-building).....	H & S
Other industries, generally.....	AE
Bridge Construction.....	See Building and Construction

Occupation or Industry—Continued

Health
ins. class

Broom and Brush Manufacture:

Proprietors:

Superintending only	AAA
Others	AA7

Foremen	AA7
---------	-----

Skilled workers	A
-----------------	---

Laborers	U
----------	---

Buffers (Metal) See Grinders (Metal)

Building and Construction:

1. General Construction:

Note:—These ratings apply where no unusual hazard exists. Certain kinds of construction work require a special rating. See list following General Construction.

Apprentices	Rate as skilled tradesmen
-------------	---------------------------

Architects	See Architects
------------	----------------

Blasters	H & S
----------	-------

Bricklayers and masons	AE
------------------------	----

Carpenters	A†
------------	----

Cement and concrete finishers	A
-------------------------------	---

Cement workers (laborers)	U
---------------------------	---

Civil engineers, transitmen and rodmen, generally	AAA
---	-----

Concrete finishers	A
--------------------	---

Concrete mixer operators	A†
--------------------------	----

Contractors and superintendents:

Not working	A
-------------	---

Working	A
---------	---

Crane, derrick, hoist, and power shovel:

Operators and firemen	A†
-----------------------	----

Oilers	H & S
--------	-------

Drillers (rock)	H & S
-----------------	-------

Dumbwaiter installers and repairers	A†
-------------------------------------	----

Electrical inspectors, city or insurance company	AAA
--	-----

Electricians wiring buildings	A†
-------------------------------	----

Floor finishers and sanders	A
-----------------------------	---

Foremen:

Supervising only	A
------------------	---

Others	Rate as skilled workers in same trade
--------	---------------------------------------

Glaziers	A
----------	---

Helpers:

Apprentices	Rate as skilled tradesmen
-------------	---------------------------

Laborers	U
----------	---

Hod carriers	U
--------------	---

Insulators rock wool, etc.	A†
----------------------------	----

Laborers	U
----------	---

Lathers	A
---------	---

Masons	AE
--------	----

Ornamental iron workers and housemaids:

Railing, fence, metal sash installers	A†
---------------------------------------	----

Fire escape, balcony, elevator, stair erectors	H & S
--	-------

Painters and varnishers:

House painters	AE
----------------	----

Interior decorating and painting	A
----------------------------------	---

Sign painters:

Outside	AE
---------	----

Shop	A
------	---

Paper hangers	A
---------------	---

Pile driver operators	H & S
-----------------------	-------

Pipefitters	A
-------------	---

Plasterers	AE
------------	----

Plumbers	A
----------	---

Riggers	H & S
---------	-------

Rod setters	A†
-------------	----

Roofers, tinnern (roofing), and cornice workers	AE
---	----

Occupation or Industry—Continued

Health
ins. class

Sheet metal workers and tinsmiths:	
Roofing	AE
Others	AA7
Shorers	H & S
Sprinkler installers	A
Stationary engineers, generally	A†
Steamfitters	A
Steam shovel operators	A†
Stone cutters	AE
Tile setters, marble, mosaic, and terrazzo workers:	
Roofing	AE
Others	AE
Tinsmiths:	
Roofing or cornice work	AE
Others	AA7
Timekeepers	AA
Tuckpointers	AE
Watchmen	H & S
Waterproofers	AE
2. Bridge and Structural Iron and Steel Construction:	
Foremen	H & S
Carpenters, electricians, painters, welders, cutters and structural iron workers	H & S
Rod setters (building construction)	A†
Laborers	U
3. Building Movers:	
Foremen and skilled workers	A†
Laborers	U
4. Building Wreckers:	
Skilled workers	U
Laborers	U
5. Domestic Water Tank, Silo, and Windmill construction:	
See specific occupation under General Construction	A†
6. Elevator Installation and Repair	A1
7. Marine (Docks, Drydocks, Breakwaters, Piles, Levees, Jetties)	
Foremen	
Bricklayers and masons; pile driver operators and firemen	H & S
Carpenters, cement finishers, and other similar skilled workers; shorers	H & S
Divers	U
Laborers	U
8. Road, Street and Sewer (Except Tunnel) Construction:	
Foremen; operators of ditching machines, graders, steam rollers, and other road building machinery; pipe layers	U
Jackhammer operators:	
Paving	A†
Rock drilling	H & S
Asphalt layers (laborers) and other laborers	H & S
9. Smokestack and Chimney Construction	U
10. Steeplejacks and Flagpole Workers	U
11. Tunnel and Shaft Construction:	
Working under compressed air:	
Foremen, all skilled workers	U
Laborers	U
Not working under compressed air:	
General operations:	
Foremen and skilled workers	U
Laborers	U
Finishing operations: Tile setters, etc.	See specific occupation under General Construction
Building Cleaning and Renovating:	
Outside:	
Sandblasters	U
Acid cleaners	U
Others	

Occupation or Industry—Continued

	<i>Health ins. class</i>
Burnishers (Metal)-----	A
Bus Drivers-----	A
Butchers:	
Retail:	
Owners-----	See Merchants—Retail (meat and fish)
Employees-----	A
Packing houses and wholesale distributors-----	A
Butlers-----	H & S
Butter Making-----	See Dairy Industry
Button Manufacture:	
Plastic buttons-----	See Plastics Industry
Bone, horn, shell (pearl), vegetable ivory:	
Foremen-----	AA7
Skilled workers-----	A
Laborers-----	U
Cabinet Makers-----	A
Cable Splicers:	
Electric light and power-----	U
Telephone and telegraph-----	H & S
Caisson Workers:	
Foremen, skilled workers-----	U
Laborers-----	U
Can Manufacture:	
Foremen-----	AA7
Skilled workers-----	A
Laborers-----	U
Candy and Confectionery:	
Foremen-----	AA7
Skilled workers-----	A
Laborers-----	U
Canning, Preserving, and Pickling:	
(Except Meat Packing, for which see under Stockyards) If seasonal work only, other occupation will be considered	
Proprietors:	
Superintending only-----	AAA
Others-----	AA7
Foremen; skilled workers-----	A
Laborers-----	U
Carborundum Manufacture-----	See Abrasives Industry
Carpenters:	
Apprentices-----	Rate as skilled tradesmen
Helpers (not apprentices)-----	Rate as laborers in particular industry
Breweries, wineries, distilleries, etc-----	A†
Building and construction:	
General construction-----	A†
Bridge and structural iron and steel-----	H & S
Caisson (compressed air)-----	U
Marine—docks, etc-----	H & S
Tunnel and shaft:	
In compressed air-----	U
Not in compressed air:	
Finishing operations-----	A†
Others-----	U
Cabinet makers-----	A
Explosives (except small arms ammunition)-----	U
Mines-----	See Mining Industry
Oil (petroleum) and natural gas industry:	
Rig, derrick, and tank building-----	H & S
Others-----	H & S
Railroads (bridge-and-building)-----	H & S
Ship and boat building:	
Large vessels—hull construction-----	H & S
Others-----	A†
Other industries, generally-----	A†

Occupation or Industry—Continued

Health
ins. class

Cartridge Manufacture.....	See Explosives Industry
Cash Register Repairers:	
Not in shop.....	AA
In shop.....	A
Caustic Soda Manufacture.....	See Alkali Manufacture
Cellophane Manufacture.....	See Artificial Silk
Celluloid and Other Proxylon Plastics.....	See Plastics Industry
Cement, Lime, and Gypsum Manufacture:	
Foreman	AA7
Skilled workers	A†
Laborers	U
Chauffeurs and Drivers:	
Driver salesmen selling to homes (bakery, dairy, laundry, etc.) ..	AA7
Explosives:	
Nitroglycerine	U
Powder, dynamite, and other high explosives.....	U
Trailer trucks (except explosives).....	H & S
Others:	
Ambulance, armored car, bus, dairy, expressmen, fuel oil, furniture and piano moving, gasoline, private family.....	A†
Ash truck, garbage and street cleaning truck, building wrecking, coal or ice truck, junk and scrap metal dealers (except pushcart), safe and machinery moving.....	H & S
Light delivery (generally).....	A†
Liquor industry:	
Breweries, wineries, distilleries, and wholesale dis- tributors	AE
Retail liquor stores.....	See Liquor and Allied Trades
Motor truck (except as otherwise stated).....	A†
Racing.....	U
Taxicab drivers:	
Owners	AE
Employees	H & S
Cheese Making.....	See Dairy Industry
Chefs.....	See Cooks and Chefs
Chemical Industry.....	See Acids, Alkali, Plastics, Nylon, etc.
Chemists, Chemical Engineers, Assayers, Metallurgists, and Labora- tory Technicians:	
Not engaged in process work.....	See particular industry
Note: If not listed under industry—analytical, laboratory, phar- maceutical—non-hazardous duties.....	AAA
Engaged in process work.....	Rate as foreman or skilled workers, depending on duties
Chiropodists	AAA
Chiropractors	AAA
Chlorine Manufacture.....	See Alkali Manufacture
Cigar and Cigarette Manufacture.....	See Tobacco Manufacture
Civil Engineers:	
Building and construction, generally.....	AAA
Railroad industry.....	AAA
Others, hazardous duties.....	U
Cleaning and Dry Cleaning Plants.....	See Dry Cleaning Plants
Clerks (Sales) and Salesmen—Retail (not delivering, not listed elsewhere):	
Art goods, books, carpets, clothing, dry goods, hats (not repair- ing), jewelry (not repairing), leather goods, linoleum, musical instruments (not repairing), optical goods, photographic sup- plies, rugs, sewing machines (not repairing), sporting goods.....	AAA
Automobile accessories.....	AA
Bakery (counterwork only).....	AAA
Drug store:	
No fountain work.....	AA
Dispensing ice cream.....	AA7
Dispensing other foods.....	See Restaurants

Occupation or Industry—Continued

Health
ins. class

Dry cleaners (counterwork only, no cleaning on premises)-----	AAA
Furniture or major household appliances (not repairing)-----	A
Grocery, meat, fish, fruit, vegetable, produce, and delicatessen--	A
Shoe (not repairing)-----	AA
Soda or ice cream dispensers-----	AA7
Clerks (not listed elsewhere) :	
Shipping (no special hazard)-----	A
Stock, light goods (no special hazard)-----	AA
Clothing Manufacture :	
Proprietors, executives, supervisors, designers-----	AAA
Pattern makers-----	AA7
Tailors, cutters, and other skilled workers-----	A
Laborers-----	U
Coal and Ice Distribution :	
Delivery of coal from mines to wholesale and retail yards	
Owners (driving) and chauffeurs-----	H & S
Helpers-----	U
Wholesale and retail dealers	
Owners, best grade, not delivering-----	A
Owners, best grade, not delivering or handling-----	A *
Other owners and chauffeurs-----	H & S
Foremen-----	A
Pushcart vendors, carriers, helpers ; wheelers, yardmen, and laborers-----	U
Coast Guard-----	See Military Services
Cobblers-----	A
Coke Ovens :	
Foremen-----	A†
Dampermen, luter men, quenching car men-----	H & S
Other skilled workers-----	A†
Hand levelers, hand oven pullers, tar chasers, and other laborers-----	U
Cold Storage Plants :	
Foremen ; shipping clerks-----	A
Skilled workers-----	A†
Laborers-----	U
Collectors :	
Accounts only-----	AA7
Repleviners, repossessioners-----	A†
Compositors-----	AA7
Compressed Gas and Liquid Air Plants :	
Acetylene-----	See Acetylene Gas
Chlorine-----	See Alkali Manufacture
Argon, dry ice (solidified carbon dioxide), hydrogen, neon, nitrogen, oxygen	
Superintendents, chemists, laboratory assistants (technicians) not engaged in process work-----	AAA
Foremen-----	AA7
Cellmen, compressor engineers, meter readers, column men, gas purification operators, scrubbers, furnacemen, pressmen (dry ice), retort tenders and similar skilled workers--	A
Cylinder maintenance men ; pipefitters-----	A†
Laborers-----	U
Concentrating, Ore-----	See Mining Industry
Concrete Block Manufacture :	
Foremen-----	AA7
Skilled workers-----	A†
Laborers-----	U
Constables :	
Making arrests or guarding prisoners-----	H & S
Others-----	AAA
Construction-----	See Building and Construction

Occupation or Industry—Continued

Health
ins. class

Cooks and Chefs:	
Hotels and restaurants, generally	A
Combination restaurants and bars	A
Night clubs and roadhouses	H & S
Saloons and beer taverns	H & S
Lumber camps	H & S
Domestic, school, and hospital	H & S
Candy cooks	A
Railroad dining car	H & S
Coopers:	
Breweries, distilleries, wineries	A†
Others—non-hazardous industries	
Using power tools	A†
Copper Mills and Foundries	See Metal Industries
Cordage Manufacture	See Textile Industry
Corn Products Manufacture	See Starch Manufacture
Cotton Mills	See Textile Industry
Countermen and Countermaids: Restaurants and lunch wagons	See Waiters and Waitresses
Cranemen:	
Abrasives manufacture—not products	A
Bridge (large) construction; lumbering and logging	H & S
Docks	
Handling coal and ore	A†
Others	H & S
General construction: glass factories and metal mills	A†
Railroad wrecking crew; shipbuilding	H & S
In most other plants	A†
Custodians	See Janitors
Dairy Industry—Milk, Butter, Cheese, Condensed Milk, Ice Cream:	
Foremen	AA7
Chauffeurs and drivers	See Chauffeurs and Drivers
Cold room skilled workers	A†
Bottlers; butter, cheese, and ice cream makers; can fillers con- densers, pasteurizers, and other similar skilled workers	A
Bottle and can washers (machine operators); platform men (not laborers)	A
Laborers	U
Decorators, Interior, not painting, varnishing, or paper hanging	AAA
Deliverymen	See Chauffeurs
Dental Hygienists	AAA
Dental Mechanics	AAA
Dentists	AAA
Detectives	See Police
Diamond Cutters and Polishers	AA
Distilleries	See Liquor and Allied Trades
Divers	U
Docks (Except dock construction):	
Dock bosses and checkers	A
Dock laborers and loaders	U
Cranemen	See Cranemen
Longshoremen and stevedores	
Foremen	H & S
Workers	U
Dredges	See Marine Industry
Drillers, not blasting:	
Rock drillers in mines	See Mining Industry—rate as skilled miners
Rock drillers in quarries	U
Rock drillers not in mines or quarries	H & S
Oil and water well drillers	A†
Drivers	See Chauffeurs

Occupation or Industry—Continued

Health
ins. class

Druggists	See Merchants
Dry Cleaning Plants	
Proprietors, managers	AA*
Foremen	AA7
Skilled workers, operating cleaning drum	A†
Laborers	U
Dry Docks	See Ship and Boat Building
Dry Ice	See Compressed Gas and Liquid Air
Dye and Dye Intermediate Manufacture :	
Superintendents, chemists, laboratory assistants (techni- cians)—not engaged in process work	AAA
Foremen	AA7
Skilled process workers	A
Laborers	U
Dyeing and Bleaching Works :	
Foremen	AA7
Skilled employees	A
Laborers	U
Electric Truck Operators	See Truck Operators
Electrical Industry :	
Bridge, tunnel, and shaft construction	See Building and Construction
Explosives industry	See Explosives Industry
Liquor and allied trades	See Liquor and Allied Trades
Radio and television broadcasting	See Radio and Television
Railroads and railways	See Railroad Industry
Telephone and telegraph	See Telephone and Telegraph
1. General :	
Electrical engineers :	
Consulting and designing	AAAA
Electrical laboratory-development, testing	AAA
Student electrical engineers	AA
Others	--
Electrical contractors :	
Wiring buildings	
Supervisory duties only	A
Working	A
Others	--
Electrical inspectors, city or insurance company	AAA
Repairers and testers of armatures, coils, condensers, meters, motors, etc.—in shops	A†
Meter readers	AAA
Electricians :	
Wiring buildings	A†
Plant maintenance men :	
Buildings and factories, generally	A†
Mines, quarries :	
Open pit and strip mines; quarries	H & S
Underground mines :	
Surface duties only—all mines	H & S
Underground duties	See Mining
2. Power Plants and Substations :	
Superintendents (power plants)	AA
Load dispatchers	AAA
Chief electricians	A†
Dynamo, generator, turbine, and switchboard operators; trans- former repairmen; stationary engineers and firemen; mainte- nance electricians	A†
Oilers	A†
Laborers	U

Occupation or Industry—Continued

Health
ins. class

3. Power Line Construction and Maintenance :

Overhead lines :

Foremen :

Climbing poles, towers----- U
 Not climbing poles, towers----- H & S

Patrolmen :

Climbing poles, towers----- U
 Not climbing poles, towers----- A†

Linemen, troublemen, cable splicers----- U

Pole setters ; tree trimmers, ground crew----- H & S

Laborers----- U

Conduits and tunnels only :

Foremen ; ground crew----- H & S

Cable splicers, linemen, troublemen----- U

Laborers----- U

4. Battery Manufacture :

Storage batteries :

Foremen :

Lead burning, mixing or pasting departments----- H & S

Other departments----- A

Chargers, developers, and formers----- A

Lead burners, molders, and solderers ; mixers and pasters----- H & S

Laborers----- U

Dry cell batteries :

Foremen----- AA7

Grinders, mixers, stampmen ; other process workers----- A

Laborers----- U

Electroplating Plants :

Foremen----- AA7

Skilled workers----- A

Laborers----- U

Electrotypers----- AA7

Elevator Inspectors (city or insurance company)----- AA

Elevator Installers and Repairers----- A†

Elevator Operators :

Starters----- AA

Operators—Passenger or freight----- A†

Embalmers----- A

Embroiderers----- A

Enamel Sprayers and Dippers, generally----- A

Engineers :

Technical :

Chemical engineers----- See Chemists

Civil engineers :

Building and construction, generally----- AAA

Railroad industry----- AAA

Others, hazardous duties----- --

Electrical engineers----- --

Mechanical engineers, generally----- AAA

Mining engineers :

Safety engineers and Government mine inspectors----- A†

Student----- --

Others----- --

Railroad :

Locomotive engineers and motormen

Diesel or electric ; subway and elevated lines----- A†

Steam----- H & S

Stationary----- See Stationary Engineers

Engravers—Lithography, Metal----- AA7

Occupation or Industry—Continued

Health
ins. class

Etchers:

Photoengraving-----	AA7
Glass—acid finishing-----	H & S

Explosives Industry:

1. Powder, Dynamite, T.N.T., Nitro-Glycerine, Fulminate of Mercury, etc.:

Duties confined entirely to buildings other than plant process buildings, e.g., administration, engineering, power plant, machine shops:

Chemists, laboratory technicians-----	AA
Others-----	--

Duties confined most of the time to buildings other than plant process buildings;

Employed most or all of the time in plant process buildings:

Superintendents, chemists, laboratory technicians-----	H & S
Foremen; process workers-----	H & S
Laborers-----	U

2. Munitions—Shells, Bombs, Grenades, Torpedoes, Percussion Caps, Bag Loading, Poison Gas, etc.

Duties confined entirely to buildings other than plant process buildings, e.g., administration, engineering, power plant, machine shops

Chemists, laboratory technicians-----	AA
Others-----	H & S

Duties confined most of the time to buildings other than plant process buildings-----

Employed most or all of the time in plant process buildings:

Proving ground ballistic engineers-----	AA
Superintendents, chemists, laboratory technicians-----	H & S
Foremen-----	H & S
Laborers-----	U
Process workers, maintenance men (pipefitters, painters, electricians, etc.)-----	H & S
Salvage workers-----	H & S

3. Cartridges (Small arms ammunition):

Office personnel-----	AAA
Chemists, laboratory technicians-----	AA
Foremen-----	H & S
Cartridge fillers and other automatic finishing machine operators-----	
Swagers, trimmers, cup washers-----	H & S
Other skilled process workers-----	H & S
Bricklayers and masons, carpenters-----	AE
Laborers-----	U

4. Fuse Manufacturing (Burning Type), Flares, Fireworkers, etc.:

Office personnel-----	AAA
Superintendents, chemists, laboratory assistants:	
Not working in process building-----	AA
Others-----	H & S
Foremen and plant maintenance men; skilled process workers--	H & S
Laborers-----	U

5. Arsenals and Ordnance Depots: .

Officers and enlisted men----- Rate according to rank—See under Military Services

Civillian employees:

Where explosives manufacture or shell loading processes are performed on the premises---- See particular explosives

Where only storage (magazines, depots) is involved:

Foremen; skilled workers-----	H & S
Laborers-----	U

Salvage workers----- H & S

6. Transportation:

Chauffeurs and helpers delivering:

Nitroglycerine-----	U
Powder, dynamite, etc-----	U

Occupation or Industry—Continued

	Health ins. class
Expressmen -----	A†
Exterminators and Fumigators :	
Using household powders, pasters, and sprays only -----	A†
Using hydrocyanic acid or other poisonous gas -----	U
Farmers (General, dairy, stock, poultry—no other occupation) :	
Owners—best grade :	
Dairy, stock, poultry -----	A
General farm products -----	H & S
Owners—others :	
Dairy, stock, poultry ; general farm products -----	H & S
Farm hands and laborers—best grade -----	U
Farm hands and laborers—others -----	U
File Cutters (Hand) -----	A
Filers :	
Hand, generally -----	A
Saw mills -----	A†
Filling Stations -----	See Automobile Service
Film Manufacture :	
Foremen -----	AA7
Cotton nitrators, silver nitrate makers, centrifugal operators, acid room skilled workers -----	H & S
Other skilled workers -----	A
Laborers -----	U
Fire Department: Officers and men -----	H & S
Fire Wardens :	
No flying -----	A†
Flying -----	--
Firemen, Stationary -----	See Stationary Firemen
Fish Curing and Packing :	
Foremen ; skilled workers -----	A
Laborers -----	U
Fishermen :	
Inland waters—bays, lakes (except Great Lakes), rivers and sounds: Officers; crews and fishermen of all vessels -----	A†
Great Lakes :	
Coming ashore daily: Officers; crew and fishermen of all vessels -----	A†
Not coming ashore daily :	
Officers, licensed engineers, and radio operators of all vessels -----	H & S
Crew and fishermen of all vessels -----	H & S
Ocean and Gulf :	
Coming ashore daily :	
Officers, licensed engineers, and radio operators of larger vessels; fishing guides -----	A†
Officers of other vessels; crew and fishermen of all vessels -----	H & S
Not coming ashore daily :	
Trawlers and draggers :	
Officers, licensed engineers and radio operators ---	U
Crew and fishermen -----	U
Other fishing vessels :	
Large boats :	
Officers, licensed engineers and radio operators ---	U
Crew and fishermen :	
Tuna fishing -----	U
Other fishing -----	U
Small boats :	
Officers, licensed engineers and radio operators ---	U
Crew and fishermen -----	U
Floor Finishers and Sanders -----	A

Occupation or Industry—Continued

Health
ins. class

Flour and Grain Mills :

Foremen	AA7
Skilled workers	A†
Laborers	U

Foremen :

Working foremen	Rate as skilled workers
Supervising foremen	See particular industry

Forest Rangers :

No flying	A†
Flying	--

Foundries	See Metal Industries
Fumigators	See Exterminators and Fumigators

Funeral Directors :

No embalming	A*
Others	A

Fur Industry (See also Hat Manufacture) :

Dealers, salesmen, and managers	AAA
Foremen	AA7
Dressing establishments :	
Skilled workers	A
Laborers	U

Furriers and fur garment shop workers :

Working with whole skins	A
Working with fur clippings only	H & S

Furniture and Piano Movers	H & S
----------------------------------	-------

Furniture Manufacture (See also Woodworking) :

Foremen	AA7
Cabinet makers	A
Saw and other machine operators	A†
Finishers, polishers, and sandpaperers	A
Upholsters	AA7
Laborers	U

Galvanizers	A†
-------------------	----

Game Wardens :

No flying	H & S
Flying	--

Garages	See Automobile Service
---------------	------------------------

Garbage Collection	See Street Cleaning and Garbage Collection
--------------------------	--

Gardeners, Nursery Workers (best grade)	H & S
---	-------

Gas :

Acetylene	See Acetylene Gas
Chlorine	See Alkali Manufacture
Natural	See Oil and Natural Gas
Oxygen, hydrogen, nitrogen, etc	See Compressed Gas and Liquid Air
Illuminating :	

Foremen	AA7
Skilled workers	A†
Gas meter inspectors or testers	AA
Laborers :	

Pipe lines	U
Others	U

Gasoline Station Managers	See Automobile Service
---------------------------------	------------------------

Gas Wells	See Oil and Natural Gas
-----------------	-------------------------

Geologists :

Mining	See Mining Industry
Field work (not mining) :	
In unexplored territory	U
Others	AA
Laboratory work only	AAA

Occupation or Industry—Continued

Health
ins. class

Glass Manufacture (See also Mirror Manufacture) :

1. All Branches :

Superintendents (office duties)	AAA
Foremen	AA7
Bricklayers, relining furnaces	AE
Cranemen	A
Mixing room skilled workers ; furnace men (skilled)	A
Laborers	U

2. Blown, Pressed, and Window Glass :

Skilled workers	A
-----------------------	---

3. Cut Glass :

Engravers, cutters	A
Pumice stone and putty polishers ; acid finishers	H & S

4. Optical Glass :

Lens grinders	AA
---------------------	----

5. Plate Glass :

Bevelers, cutters, dressers, grinders, layers, and polishers	A
Casting house skilled workers	A
Other skilled workers	See Glass—All Branches

Glaziers

A

Glue Manufacture :

Superintendents, chemists, laboratory assistants (technicians)— not engaged in process work	AAA
Foremen	AA7
Skilled workers	A
Laborers	U

Grain Elevators and Grain Mills :

Foremen	AA7
Skilled workers	A†
Laborers	U

Greenhouse Proprietors, superintending only

AAA

Grinders, Buffers, and Polishers (Metal) :

Completely automatic grinding or polishing	A
Hand grinding, polishing, and buffing :	
Using sandstone wheels	H & S
Using composition wheels, carborundum, etc. :	
Foundries and metal mills	H & S
Others	H & S
Using cloth, leather, or felt wheels	A

Grinding Wheel Manufacture

See Abrasives Industry

Guards :

Banks and office building	AA
Customs guards	A†
Industrial plants :	
Gate house	A†
Watchmen :	
Explosives plants	H & S
Others	H & S
Payroll, armored car	A†
Prisons	H & S
Private estates	H & S
Subway and elevated railways	H & S

Gypsum Manufacture

See Cement Manufacture

Hair Goods Manufacture :

Foremen ; skilled workers	A
Laborers	U

Hairdressers

See Beauty Parlors

Hardeners (Metal)

A†

Hat Cleaning Establishments :

Proprietors	H & S
Employees	See Bootblack and Hat Cleaning Establishments

Occupation or Industry—Continued

Health
ins. class

Hat Manufacture (Fur and wool felt hats) :

Front shop operations :

Foremen ----- A

Blockers, curlers, flangers, shavers, singers, pouncers, trimmers, binders, wetters, and other skilled workers ----- A

Back shop operations :

Foremen ----- A

Blockers, blowers, driers, hardeners, mixers, pouncers, sizers, starters, stiffeners, weighers, wetters-down, and other skilled back shop workers ----- H & S

Hatters' fur shops :

Foremen ----- A

Blowers, brushers, carroters, cutters, sorters, and other skilled workers ----- H & S

Laborers (all departments) ----- U

Hemp Mills ----- See Textile Industry

Hod Carriers ----- U

Horse Racing ----- See Amusements and Sports

Hospitals :

X-ray and radium services ----- See X-ray and Radium

Bacteriologists :

Routine laboratory work ----- AAA

Others -----

Nurses, incl. student nurses :

Females ----- H & S

Males ----- H & S

Physiotherapists, physical therapists ----- AAA

Orderlies and attendants :

Mental hospitals ----- H & S

Others ----- H & S

Ambulance drivers ----- A†

Cooks ----- H & S

Tray girls ----- H & S

Dishwashers and similar kitchen help ----- U

Elevator operators ----- A†

Laundry—skilled operatives ----- A

Porters ----- U

Hotels :

Proprietors and managers :

Establishments where the sale of alcoholic beverages is a large part of the business ----- See Liquor and Allied Trades—rate as Combination Restaurant and Bar

Establishments where alcoholic beverages are not sold or are sold as a side line :

Good to excellent accommodations ----- AAA

Others ----- AA7

Cooks and chefs, generally ----- A

Bell boys ----- H & S

Maids and other female servants ----- H & S

Dishwashers and similar kitchen help ----- U

Waiters :

Alcoholic beverages served ----- See Liquor and Allied Trades

Others ----- H & S

Waitresses :

Alcoholic beverages served ----- See Liquor and Allied Trades

Others ----- H & S

Porters ----- H & S

Ice Cream Manufacturing ----- See Dairy Industry

Ice Dealers ----- See Coal and Ice

Ice Manufacture :

Foremen ----- AA7

Skilled workers ; stationary engineers ----- A†

Laborers ----- U

Occupation or Industry—Continued

Health
ins. class

Inspectors (See also particular industry) :	
Foods and drugs ; health departments ; immigrants—in city-----	AAA
Liquor package stores-----	See Liquor and Allied Trades—Liquor Law Enforcement
Postal service inspectors, not detectives-----	AAA
Slaughter and packing houses (Government or company—no process work) -----	AAA
Iron and Steel Mills and Foundries-----	See Metal Industries
Janitors :	
Apartment houses, churches, and schools	
Best grade-----	A†
Other janitors-----	H & S
Banks-----	
Best grade-----	H & S
Other janitors-----	H & S
Factories and office buildings, generally-----	H & S
Japanners-----	See Painters
Jewelry Manufacture :	
Proprietors :	
Superintending only-----	AAA
Others-----	AA
Foremen-----	AA
Polishers and buffers : leather, felt, or cloth wheels ; rollers, electroplaters (silver and other), colorers ; enamelers (hand) of buttons and other small parts-----	A
Laborers-----	U
Junk and Scrap Metal Dealers, driving, including chauffeurs (not pushcarts) -----	H & S
Jute Mills-----	See Textile Industry
Knitting Mills-----	See Textile Industry
Laboratory Technicians-----	See Chemists
Laborers-----	See particular industry
This title includes cleaners (factory), helpers (not apprentices), hod carriers, loaders, muckers, pilers, shovelers, stockers, sweepers (factory), truckers (hand), unloaders, wheelers, yardmen, as well as persons designated as common laborers.	
Lacquer Manufacture-----	See Paint
Lacquerers-----	See Painters
Laundries :	
Proprietors or managers	
Superintending only-----	AA*
Others-----	
Delivering-----	AA7
Not delivering-----	AA
Foremen-----	AA7
Dry cleaners (operating cleaning drum)-----	A†
Other skilled workers-----	A
Laborers-----	U
Laundresses (day's work)-----	H & S
Lead Burners :	
Storage batteries and chemicals manufacture-----	H & S
Others-----	H & S
Lead Smelting and Refining-----	See Metal Industries
Lead Workers-----	See Metal Industries
Leather Manufacturer :	
Artificial leather-----	See Artificial Leather
Patent leather-----	See Patent Leather
Tanneries-----	See Tanneries
Leather Products Manufacture :	
Proprietors :	
Superintending only-----	AAA
Others-----	AA7
Foremen-----	AA7
Skilled workers-----	A
Laborers-----	U

Occupation or Industry—Continued

Health
ins. class

Life Guards:	
Pools or beaches.....	H & S
Coast Guard Service.....	See Military Services
Lime Manufacture.....	See Cement Manufacture
Linemen:	
Electric light and power.....	U
Telephone and telegraph.....	H & S
Railroads:	
Power lines.....	U
Telephone and telegraph.....	H & S
Signals:	
Subways.....	H & S
Other lines.....	H & S
Linoleum and Oilcloth Manufacture:	
Foremen.....	A†
Stone dressers.....	AA7
Other skilled workers.....	A†
Laborers.....	U
Linotypers.....	AA7
Liquor and Allied Trades—U.S. & Canada:	
1. Breweries, Distilleries, Wineries, and Bottling Works:	
Proprietors and executives:	
Office duties only.....	AAAA
Others (sales or plant duties).....	AA
Office staff:	
Supervisory.....	AAAA
Others.....	AAAA
Salesmen and collectors:	
Sales managers:	
Contacting only wholesale jobbers, department stores, state operated liquor stores.....	AAA
Contacting general retail trade (primary duties).....	AA
Salesmen, collectors, window decorators, etc.:	
Wholesale contacts only.....	AA
Retail contacts.....	AA
Foremen—all departments.....	A†
Manufacturing (including bottling department) employees:	
Plant superintendents, chemists, brewmasters.....	AAA
Examiners, inspectors, gaugers (company employed).....	AA
All skilled process workers.....	A†
Laborers (ashmen, cleaners, etc.).....	U
Shipping department, transportation, and warehouse employees:	
Shipping clerks.....	A†
Truck drivers.....	AE
Garage mechanics.....	H & S
Platform loaders (primary duties).....	H & S
Laborers.....	U
Maintenance employees.....	A†
2. Wholesale Houses and Distributors: (Beer, wine, liquor, cordials, etc.).....	See Breweries, Distilleries, Wineries
3. Retail Stores handling beer, wine or liquor for consumption off premises:	
Beer, wine, or liquor handled as side line.....	Usual trade ratings apply
Beer (wine, or liquor handled as the principal commodity):	
Owners, managers, and clerks:	
Liquor department stores, state-operated stores, and other best grade retail stores.....	AAA
Other retail stores:	
Owners, managers.....	AA
Clerks.....	AA
Deliverymen:	
Best grade.....	A†
Others.....	A†

Occupation or Industry—Continued

Health
ins. class

4. Restaurants, including First Class Hotel Restaurants, Cafeterias, Delicatessens, etc. where alcoholic beverages are sold as side line :
- | | |
|---|-------|
| Proprietors and managers..... | A* |
| Stewards and cashiers..... | AA |
| Headwaiters and hostesses..... | H & S |
| Waiters, counter men, and bus boys..... | H & S |
| Waitresses and counter girls..... | H & S |
| Bartenders..... | H & S |
5. Hotel Restaurants :
- | | |
|---|--|
| Establishments where alcohol beverages are sold as a side line : | Rate as |
| Good grade..... | Restau-
rants |
| Others : | |
| Proprietors and managers..... | A* |
| Stewards and cashiers..... | AA |
| Waitresses..... | H & S |
| Waiters and bus boys..... | H & S |
| Bartenders..... | H & S |
| Establishments where the sale of alcoholic beverages is a large part of the business..... | Rate as
Combina-
tion Res-
taurants
and Bars |
6. Hotel Bars, Cocktail Lounges :
- | | |
|--|---|
| Good grade : | |
| Managers and assistant managers..... | A |
| Headwaiters, stewards, and cashiers..... | H & S |
| Headwaitresses and waitresses..... | H & S |
| Waiters and bus boys..... | H & S |
| Bartenders..... | H & S |
| Others..... | Rate as Sa-
loons,
Taverns,
etc. |
7. Combination Restaurants and Bars, where meals and alcoholic beverages are of about equal importance :
- | | |
|---------------------------|-------|
| Owners and managers..... | A*† |
| Headwaiters..... | H & S |
| Waiters and bus boys..... | H & S |
| Waitresses..... | H & S |
| Bartenders..... | H & S |
| Cooks..... | A |
8. Saloons, Taverns, Night Clubs, Roadhouses, and Similar Drinking Places :
- | | |
|------------------------------|-------|
| Owners, managers..... | H & S |
| Headwaiters..... | H & S |
| Waiters and bus boys..... | H & S |
| Waitresses..... | H & S |
| Cooks : | |
| Night clubs, roadhouses..... | H & S |
| Saloons, taverns, etc..... | H & S |
| Bartenders..... | H & S |
| Other employees..... | ----- |
9. Bowling Alleys, Billiard and Pool Rooms, Dance Halls, and Skating Rinks, serving beer, wines, or liquor :
- | | |
|-------------------------------|-------|
| Proprietors and managers..... | A*† |
| Waiters..... | H & S |
| Waitresses..... | H & S |
| Pin boys..... | U |
| Bartenders..... | H & S |

Occupation or Industry—Continued

Health
ins. class

10. Liquor Law Enforcement:

Government examiners, inspectors, gaugers at breweries, distilleries, wineries, etc.; government warehouse clerks----- AA
 State alcohol tax investigators:

No arrest duties----- AA

Making arrests----- H & S

Liquor law enforcement agents----- H & S

Lithography----- See Printing and Publishing

Livery Stable Employees----- U

Locksmiths, generally----- AA

Longshoremen----- See Docks

Lumbering and Logging:

Railroads----- See Railroad Industry

Saw and planing mills----- See Saw and Planing Mills

Superintendents, timekeepers, timber cruisers, surveyors, and clerks----- AA

Cullers, scalers, tallymen----- H & S

Foremen----- H & S

Rivermen and woodsmen:

Rivermen and raftsmen----- U

High climbers, squirrelmen, high riggers, skidder riggers, and toppers----- U

Barkers, fallers, and other similar workers:

British Columbia, California, Oregon, Washington----- U

Other states and provinces:

Pulpwood logging----- U

Other logging----- U

Cooks, cookees, camp crew----- U

Truck drivers and cranemen----- H & S

Lunch Wagons----- See Restaurants

Machinists and Machine Shop Workers:

Note: Give a complete description of duties as called for in Q. 12. Applicants doing considerable grinding, millwright work, welding, etc., are to be rated as grinders, millwrights, etc. Occasional tool grinding will be disregarded.

Machinists, operators of boring machines, drills, lathes, milling machines, planners, reamers, saws, screw machines, shapers, slotters, and punch presses:

In explosives industries----- See Explosives Industry

In other industries, generally----- AA7

Grinders, polishers, buffers----- See Grinders (Metal)

Millwrights----- See Millwrights

Mail Carriers:

City and R.F.D. mail carriers----- AA

Chauffeurs, drivers—mail trucks and wagons----- A†

Helpers—mail trucks and wagons----- A†

Malt Manufacture:

No manufacturing of alcoholic liquors:

Foremen----- AA7

Grinders, maltsters, steepers, kiln men, baggers, and other skilled workers----- A

Laborers----- U

Manufacturing of alcoholic liquors----- See Liquor and Allied Trades

Manicurists----- H & S

Marine Corps----- See Military Services

Occupation or Industry—Continued

Health
ins. class

Marine Industry :

Barges, Tug Boats, Lighters :

Officers :

Tugboats-----	A†
Barges, lighters	
Inland waters-----	H & S
Others-----	H & S

Members of the crew----- U

Dredges :

Officers and marine engineers-----	A†
Firemen, levermen, mechanics, winchmen-----	H & S
Oilers and other members of the crew-----	H & S

Harbor Pilots----- A†

Inland Waterways—Ferries, Passenger and Cargo Steamships :

Officers-----	A†
Members of the crew-----	H & S

Ocean Going, Gulf, and Great Lakes Steamships :

Officers and radio operators-----	U
Seamen, firemen, oilers, water tenders, and other crew members-----	U

Marshals :

Making arrests or guarding prisoners-----	H & S
Others-----	AAA

Masons----- See Bricklayers and Masons

Manufacture :

Foremen-----	AA7
Skilled workers-----	A
Laborers-----	U

Mattress and Pillow Manufacture :

Proprietors	
Superintending only-----	AAA
Others-----	AA
Firemen-----	AA7
Mowers, fillers, garnetting machine operators, hair spinners, pickers, etc-----	H & S
Mover makers, cutters, roll edgers, packers, sewers, spring mak- ers, upholsterers, and similar finishing occupations-----	A
Laborers-----	U

Packing----- See Stockyards

Mechanics :

The title "Mechanic" is indefinite. Com-
plete description of duties must be given---Rate according to occupational du-
ties When employed in aircraft
manufacturing, air transport, air-
port or aerial service, see Aviation.

Merchants, Retail :

Art goods, books, carpets and rugs, clothing, dry goods, leather
goods, linoleum, optical goods, photographic supplies, and
sporting goods :

Not delivering-----	AAA
Delivering-----	AA7

Bakeries----- See Bakeries

Bicycles, hats, jewelry, and musical instruments :

Superintending only-----	AAA
Others	

Repair work, manufacture-----	AA
Delivering-----	A†

Candy stores----- AA

Drug stores :

No fountain duties-----	AAA
Others-----	AA

Furniture or major household appliances :

Delivering-----	A†
Not delivering :	
Large stores—6 or more full time employees-----	A*
Others-----	A

Occupation or Industry—Continued

Health
ins. class

Groceries, delicatessens, fruits and vegetables:	
Not delivering:	
Large stores—6 or more full time employees.....	A*
Others	A
Delivering	A†
Liquor package stores.....	See Liquor and Allied Trades
Meat and fish:	
Not delivering.....	A
Delivering	A†
Shoes:	
No repairing.....	A
Repairing	AAA
Merchants, Wholesale:	
Junk and scrap metal:	
Driving	H & S
Others	A
Meat, fruit, produce:	
Driving	A†
Others	A*
Others:	
Handling merchandise, not delivering.....	AA
Delivering	A†
Metal Industries—Hot Metal Working Mills: Iron and Steel Mills and Foundries, Rolling Mills, Lead and Zinc Smelters, etc.:	
1. General:	
Casting cleaners.....	See particular occupation below
Chippers	H & S
Core makers, cranemen, forgemen, hammermen, hoistmen, mill- wrights, molders (not pouring), picklers, welders.....	A†
Cottrell treaters, arsenic recovery workers, baghouse operators...	H & S
Galvanizers and tanners.....	A†
Grinders	
Laborers	U
Pattern makers.....	A
Sandblasters:	
Fully automatic or using steel shot.....	H & S
Others	H & S
Scratchers, tumbling barrel operators.....	H & S
2. Furnace Departments, including soaking pits:	
Superintendents, assistant superintendents, and metallurgists...	AAA
Foremen (supervising), open hearth melters (supervisors), timekeepers, weighmasters.....	A
Furnacemen, blowers, bricklayers and masons, casters, heaters, ladlers, mixermen, molders (pouring), melters (not super- vising) and helpers, potmen (aluminum), pourers, puddlers, roasters, sinterers, skip operators, smeltermen, and other skilled workers around furnaces	
Brass, bronze, lead, and zinc.....	H & S
Iron and steel and other metals.....	A†
Tank tenders and operators in electrolytic refineries.....	A†
Bottom makers, cinderemen, crane hookers, fluxers, ladle clean- ers, loaders (hand), pilers, sand cutters, stockers, stove clean- ers, trestle men, yardmen, and other laborers.....	U
3. Rolling and drawing mills—blooming, bar, billet, plate, rail, rod, slabbing, sheet and tinplate, tube, wire, and nail mills	
Superintendents, assistant superintendents, and metallurgists...	AAA
Foremen (supervising), timekeepers, and weighmasters.....	A
Skilled workers.....	A†
Bundlers, car loaders, crane followers, and other laborers.....	U
Metal Products Manufacture:	
Foremen	AA7
Spinners, sheet cutters, assemblers, and stamp press hands.....	A
Other workers.....	See particular occupation
Laborers	U
Metallurgists	
	AAA

Occupation or Industry—Continued

Health
ins. classMilitary Services—Air Force, Army, Navy, Marine Corps, Coast
Guard:

Note: Specify: (a) the applicant's rank or rating, (b) the service (Army), Navy, etc.), (c) the arm or branch (submarine, air-borne infantry, paratroopers, etc.), and (d) any hazardous duty for which extra pay is received.

On flying status, or duties connected with aviation----- See Aviation

Submarine service

Military Pay Grades E1-E3----- U

Military Pay Grades E4-E9, warrant and commissioned
officers----- U

Other duty with extra hazard pay-----

Branches of the services with normal pay duty

Military Pay Grades E1-E3----- U

Military Pay Grades E4-E9, warrant officers----- U

Cadets, U.S. Air Force, Military, Naval or Coast Guard
Academies, and commissioned officers graduate thereof
within two years----- U

Other commissioned officers, generally----- U

Millwrights—Machinery Maintenance:

Apprentices----- Rate as skilled tradesmen

Helpers (not apprentices)----- Rate as laborers in particular industry

Abrasives manufacture----- H & S

Acid, alkali, and ammonia manufacture----- A†

Boiler and tank manufacture----- A†

Breweries, wineries, distilleries, etc----- A†

Cement, gypsum, and lime manufacture; coke ovens----- A†

Explosives (except small arms ammunition)----- H & S

Insecticide manufacture—arsenic, lead, poisonous gas, etc----- H & S

Metal mills and foundries----- A†

Mines:

Entering underground mines more than twice monthly----- H & S

All others----- H & S

Ore dressing and concentrating mills----- H & S

Sawmills and planing mills where logs are sawn----- A†

Mining, Quarrying, Ore Dressing, and Concentrating:

Mining:

All mines—operators, officials, superintendents, managers, min-
ing engineers, geologists-----

Safety engineers and Government mine inspectors----- A†

Underground workers:

All mines:

Foremen, clerks, weighers; blacksmiths, electricians,
machinists, tool dressers; crane and hoist operators, der-
rickmen, stationary engineers and firemen----- H & S

Other workers:

Anthracite mines:

Plans with *elective* Additional Indemnity (e.g.

Tower Series, except Family Plans):

Skilled workers----- H & S

Laborers----- U

Plans with *automatic* Additional Indemnity (e.g.

Metropolitan Series and all Family Plans):

Skilled workers----- H & S

Laborers----- U

Bituminous coal mines:

Skilled workers----- H & S

Laborers----- U

Iron, limestone, nickel and taconite mines:

Skilled workers----- H & S

Laborers----- U

Salt and potash mines:

Skilled workers (excluding blasters)----- H & S

Blasters----- H & S

Laborers----- U

Copper, and all other mines:

Skilled workers----- H & S

Laborers----- U

Occupation or Industry—Continued

	Health ins. class
Surface and open pit mine workers :	
Blasters	U
Foremen, power shovel operators, and other skilled workers	H & S
Laborers	U
Outside workers :	
Wash-house, breaker, or tippie :	
Foremen, panel control board operators and other skilled automatic process workers	H & S
Other skilled workers	H & S
Laborers	U
Electricians :	
Not entering mines :	
Maintenance men	H & S
Others	Rate according to duties. See Electrical Industry
Entering mines :	
Surface and open pit mines	H & S
Underground mines	H & S
Millwrights :	
Entering underground mines more than twice monthly	H & S
All others	H & S
Blacksmiths, bricklayers, carpenters, weighers, hoistmen, pipefitters, machinists, etc., and their foremen :	
Not entering mines	AE
Entering mines :	
Surface and open pit mines	H & S
Underground mines :	
Not more than twice monthly	H & S
Others	U
Laborers on surface :	
Not entering mines	U
Entering mines	Rate as laborers in mines
2. Ore Dressing and Concentrating :	
Rock house men ; stamp, crusher, and grinding mill tenders	H & S
Jig, concentrating table, flotation tank, and vanner runners	A†
Stationary engineers and firemen	A†
Laborers	U
3. Quarry and Sand Pit men :	
Not blasting	
Foremen, cranemen, derrickmen, hoistmen, shovel operators, stationary engineers and firemen, tool dressers	H & S
Others	H & S
Blasting (including foremen)	U
Laborers	U
Mirror Manufacture (See also Glass Manufacture) :	
Foremen	AA7
Grinders, bevelers, silverers, mirror backers, and other skilled workers	A
Laborers	U
Molders—Metal Industry	See Metal Industries
Monotype Keyboard Operators	See Printing and Publishing
Monument Shops :	
Proprietors or managers	AA
Carvers, cutters, letterers (carvers)	H & S
Sandblasters :	
Fully automatic	H & S
Others	H & S
Morticians	See Undertakers and Embalmers
Motion Pictures	See Amusements and Sports
Movers	See Building and Construction or other industry involved
Munitions	See Explosives Industry

Occupation or Industry—Continued

Health
ins. class

Musicians :	
Concert, symphony	AAA
Dance orchestra and others, best grade	A
Natural Gas	See Oil and Natural Gas
Navigation	See Marine Industry
Navy	See Military Services
Neon Light Signs :	
Foremen	AA7
Glass benders, blowers, layout men, pumpmen (bombarders) ..	A
Nursery Proprietors, superintending only	AAA
Nurses	See Hospitals
Nylon Manufacture :	
Superintendents, chemists, and laboratory assistants (technicians)—not engaged in process work	AAA
Foremen	AA7
Finishing departments—twisting, winding, weaving, and other textile processes Skilled workers	A
Preparation departments :	
Polymer preparing operators, auto-clave operators, casters	A
Blenders, chargers (heating hoppers), patrollers (spinning), spinners, spinnerette tenders	A
Laborers	U
Oil and Natural Gas Industry :	
Geophysical exploration	U
Oil operators and superintendents	AA
Foremen :	
Rig, derrick, and tank building	H & S
Others	AA
Contractors (derrick building)	A†
Rig, derrick, and tank builders	U
Derrickmen, roughnecks	H & S
Drillers (not using explosives)	A†
Shooters and drillers (using explosives) :	
Geophysical exploration—seismic method	U
Others	U
Pumpmen, tool dressers, pushers; oil gaugers	A†
Roustabouts, laborers	U
Pipe lines—inspectors, pumpers, pipe line walkers	A†
Welders and cutters	See Welding and Cutting
Oil Refineries :	
Acid recovery workers	A†
Butane, propane, etc.	
Cylinder charging operators, fillers	A†
Ethyl gasoline blenders	A†
Filter pressmen; oil compounders, testers and treaters; pumps	A†
Plumbers, pipefitters, steam fitters	A†
Stillmen	A†
Still cleaners	U
Laborers	U
Oilcloth Manufacture	See Linoleum
Oilers :	
Building (general construction)—crane, derrick, etc.	H & S
Electric power plants and substations	A†
Iron and steel (car, crane, machines, etc.)	H & S
Railroad roundhouses	H & S
Ships and dredges	See Marine Industry
Optical Instruments Manufacture :	
Skilled workers	AA
Laborers	U

Occupation or Industry—Continued

Health
ins. class

Opticians :

Shop work—cutters, lens grinders, etc..... AA

Others AAA

Ore Dressing and Concentrating..... See Mining Industry

Orthodontists AAA

Osteopaths AAA

Packing Houses..... See Stockyards

Paint and Paint Pigment Makers :

Burners, grinders, color makers..... H & S

White lead makers..... See White Lead

Laboratory testers..... AA

Paint mixing machine operators..... A

Laborers U

Painters, Varnishers, and Lacquerers :

Apprentices..... Rate as skilled tradesmen

Helpers (not apprentices)..... Rate as laborers in particular industry

Automobiles..... A

Breweries, wineries, and distilleries..... A†

Building and construction :

General construction..... AE

Bridge and structural iron and steel ; marine—dock, etc..... H & S

Steeple and flagpole..... U

Tunnel and shaft finishing operations..... AE

Dial painters..... See X-ray and Radium

Explosives (except small arms ammunition)..... H & S

Potteries..... See Potteries

Railroads :

Bridge-and-building..... H & S

Repair shops..... A†

Ships :

Large vessels :

Interior finishing only..... A†

Others AE

Small boats..... A†

Signs :

Outside..... AE

Shop only..... A

Others industries, generally :

Factory products painters..... A

Maintenance men..... A†

Paper and Pulp Mills :

Proprietors :

Superintending only..... AAA

Others..... A

Foremen (all departments)..... AA7

Wood department :

Sawyers..... A†

Pondmen, log and boom men..... H & S

Barkers, chippers, grinders, skimmers, splittermen..... A†

Yardmen (skilled)..... H & S

Paper and pulp departments :

Skilled workers..... A†

Rag sorters..... H & S

Laborers..... U

Paper Hangers..... A

Parcel Room Checkers..... AA7

Patent Leather :

Foremen..... AA7

Mixers, coaters, and other skilled workers..... H & S

Laborers U

Occupation or Industry—Continued

Health
ins. class

Pattern Makers :	
Clothing manufacture	AA7
Others, generally	A
Pawnbrokers	AA
Peddlers	H & S
Photoengraving	See Printing and Publishing
Photographers :	
Motion pictures, newspapers, and others doing aerial or "stunt" work	
Photoengraving and motion picture "stills"	AAA
Others, generally	AAA
Physicians and Surgeons	AAA
Physiotherapists, Physical Therapists	AAA
Picklers (Metal)	A†
Pickling	See Canning, Preserving, and Pickling
Pillow Manufacture	See Mattress and Pillow Manufacture
Pin Ball Games	See Amusements and Sports
Pipefitters	See Plumbers
Planing Mills	See Saw and Planing Mills
Plasterers	AE
Plastics Industry :	
Bakelite, catalin, celluloid, fiberloid, lucite, micrata, etc :	
Superintendents, chemists, laboratory assistants (technicians)—not engaged in process work	AA7
Foremen	AAA
Skilled workers :	
Preparation department	A
Articles manufacturing	A
Plumbers, pipefitters, steamfitters	A†
Laborers	U
Platers (Electroplaters)	A
Plumbers, Pipefitters, and Steamfitters :	
Apprentices	Rate as skilled tradesmen
Helpers (not apprentices)	Rate as laborers in particular industry
Building and construction :	
General construction	A
Bridge and structural iron and steel	H & S
Caisson workers	U
Marine—docks, etc.	H & S
Tunnel and shaft :	
In compressed air	U
Not in compressed air :	
Finishing operations only	A
Others	H & S
Acid, alkali, and ammonia manufacture	A†
Artificial leather and synthetic rubber; artificial silk and cellophane manufacture	A†
Breweries, wineries, distilleries, etc.	A†
Coke ovens; compressed gas	A†
Explosives (except small arms ammunition)	U
Mines	See Mining Industry
Oil refineries; plastics (pyroxylin and non-pyroxylin)	A†
Quarries	H & S
Rubber (synthetic) manufacture; ship and boat building; white lead manufacture	A†
Other industries, generally	A†

Occupation or Industry—Continued

Health
ins. class

Police and Law Enforcement:

Guards----- See Guards
Prisons----- See Prisons

General:

Constables, marshals, sheriffs, and their deputies:

Making arrests or guarding prisoners----- H & S
Others----- AAA

Probation and parole officers----- AA

Federal:

Customs and immigration guards:

No field patrol or criminal investigating duties and not
making arrests----- A
Others----- H & S

F.B.I. special agents; Narcotic law enforcement agents:

Secret Service agents----- H & S

Liquor law enforcement----- See Liquor and Allied Trades

State, county, city, and town police:

Captains and higher ranks----- A†

Lieutenants, sergeants, detectives, and policemen; motor-
cycle police----- H & S

Policewomen----- H & S

Private police and detectives:

Detective agencies—private detectives:

Office duties only----- H & S
Others—best grade----- H & S
Others—not best grade----- H & S

Railroads:

Passenger stations----- H & S
Yards, tracks, etc----- H & S

Polishers----- See particular industry

Pool Room----- See Amusements and Sports

Porters:

Hotels, office buildings, etc.; pullman porters----- H & S

Potteries—Chinaware, Porcelain, Tile:

Foremen----- AA7

Glaze grinders, makers, and mixers----- H & S

Spar and flint workers (skilled)----- H & S

Sandblasters

Fully automatic----- H & S

Others----- H & S

Other skilled workers----- A

Sagger washers and laborers----- U

Preserving----- See Canning, Preserving, and Pickling

Printing and Publishing:

1. General:

Proprietors

Superintending only----- AAAA
Others----- AA7

Copyholders, proofreaders----- AAA

Other skilled workers----- AA7

Laborers, all departments----- U

2. Lithographing:

Press feeders and pressmen, transferrers, proofers, designers,
engravers----- AA7

3. Photoengraving:

Artists----- AAA

Photographers----- AAA

Blockers, finishers, proofers, routers, and etchers----- AA7

4. Type Founders----- A

Prisons and Other Penal Institutions:

Wardens and other officials----- AA

Guards, jailers, keepers, and instructors----- H & S

Pyroxylin Plastics Manufacture----- See Plastics Industry

Quarrying----- See Mining Industry

Occupation or Industry—Continued

Health
ins. class

Radio and Television :	
Aerial installation.....	AE
Broadcasting stations :	
Control room operators, transmission engineers, maintainers, and operators.....	AA
Radio operators and technicians	
Air transport, airport, or aerial service.....	—
Others :	
On land.....	A
On ships.....	See Marine Industry
Radium.....	See X-ray and Radium
Railroad Industry :	
1. Diesel, Electric, and Steam Railroads, including Plant Railroads :	
Passenger station employees :	
Station masters and agents, telegraphers, trainmasters, dispatchers, ticket agents, and clerks with office or station duties only.....	AAA
Gatemen and train announcers.....	A
Baggage and parcel room attendants.....	AA7
Baggage and mail truckers.....	A†
Car cleaners ; porters and janitors.....	H & S
Freight stations and warehouses :	
Freight clerks, recorders, checkers, inspectors, and weighers—no yard duties.....	A†
Truckers and laborers.....	U
Train employees :	
Conductors and ticket collectors.....	AA
Brakemen and flagmen :	
On passenger trains only.....	AE
On freight, yard, mixed, and construction trains.....	H & S
Baggagemen, express messengers, and mail clerks.....	A†
Engineers and motormen :	
Diesel or electric.....	A†
Steam.....	H & S
Firemen and helpers.....	H & S
Dining and club cars :	
Stewards.....	AA
Waiters and cooks.....	H & S
Waitresses.....	H & S
Pullman car porters.....	H & S
Yard employees :	
Yardmasters, assistant yardmasters, foremen ; crew callers.....	A†
Yard clerks—car checkers, chalkers, sealers, tracers, and weighers.....	AE
Car icers ; car inspectors, airbrake inspectors, and repairmen.....	H & S
Switch tenders, levermen :	
In towers.....	A†
Not in towers.....	H & S
Laborers, car cleaners.....	U
Maintenance of way and structures :	
Bridge-and-building carpenters, masons, painters.....	H & S
Bridge builders or repairers (iron workers).....	H & S
Bridge tenders and crossing flagmen :	
In towers.....	A†
Not in towers.....	H & S
Civil engineers*, surveyors, rodmen, and chainmen.....	AA
Power lines :	
Linemen, third rail repairers, troublemen.....	U
Groundmen.....	U
Laborers.....	U
Rail welders, bonders, and grinders.....	H & S

Occupation or Industry—Continued

Health
ins. class

Signals, telephone and telegraph :	
Foremen.....	A†
Signal maintainers, linemen; battery men, lampmen and groundmen.....	H & S
Laborers.....	U
Section gangs and wrecking crews :	
Foremen, supervisors.....	A†
Wrecking train crew—skilled workers and cranemen.....	H & S
Section hands, laborers, and track walkers.....	U
Roundhouse, repair shop, and repair track employees :	
Foremen.....	AA7
Arc welders, acetylene burners or cutters.....	A†
Inspectors and repairers of airbrakes, boilers, signals, wheels, etc.; boilermakers, cranemen, and mechanics; car- penters, electricians.....	A†
Engine hostlers and firemen; oilers and engine wipers.....	H & S
Locomotive or car painters.....	A†
Fire builders and knockers, flue and boiler cleaners, and other laborers.....	U
Police and detective force :	
Passenger stations.....	H & S
Yards, tracks, etc.....	H & S
Powerhouses and substations.....	See Electrical Industry— Power Plants and Substations
2. Electric Railways—Interurban, Elevated, Surface, and Subway Lines :	
Transportation :	
Change booth clerks.....	AAA
Conductors and motormen.....	A†
Brakemen; train and platform guards.....	H & S
Dispatchers.....	AAA
Switch tenders and levermen :	
In towers.....	A†
Not in towers.....	H & S
Porters.....	H & S
Maintenance of way and structures :	
Foremen, section and track :	
Subways.....	H & S
Other lines.....	A†
Painters.....	AE
Rail welders, bonders, and grinders.....	H & S
Track laborers, walkers, and greasers.....	U
Power line maintenance men.....	H & S
Signal and lamp maintenance men :	
Subways.....	H & S
Other lines.....	H & S
Car barns and repair shops :	
Electricians and armature men.....	A†
Repairmen and inspectors of airbrakes, air compressors, sig- nals, wheels, etc., battery men.....	A†
Repairmen, bench work only.....	A
Car painters; welders.....	A†
Greasers and oilers.....	H & S
Car cleaners and laborers.....	U
Powerhouses and substations.....	See Electrical Industry— Power Plants and Substations
Nylon.....	See Artificial Silk
Restaurants :	
Proprietors and managers :	
Establishments handling beer, wine, liquor for consump- tion on premises.....	See Liquor and Allied Trades
Other establishments :	
No cooking or kitchen duties.....	A*
Cooking or kitchen duties.....	A

Occupation or Industry—Continued

Health
ins. class

Cooks and chefs.....	See Cooks and Chefs	
Dishwashers and similar kitchen help.....	U	
Waiters and countermen:		
Beer, wine, or liquor served.....	See Liquor and Allied Trades	
Others	H & S	
Waitresses and countermaids:		
Beer, wine, or liquor served.....	See Liquor and Allied Trades	
Others	H & S	
Riggers:		
Building wreckers.....	U	
Lumbering and logging—skidder riggers.....	U	
Others, generally.....	H & S	
Rollers (Metal).....	See Metal Industries—	
	Rolling and Drawing Mills	
Roofers	AE	
Roofing Materials Manufacture—Asphalt (Asbestos—see Asbestos)		
Foremen	AA7	
Inspectors	AA	
Stillmen, hydraulic press operators, asphalt coating machine operators, pumpmen.....	A†	
Pulverizers, mineral coaters, mixers.....	U	
Laborers	U	
Rope Mills.....	See Textile Industry	
Rubber and Rubber Products:		
1. General Processes:		
Foremen	AA7	
Skilled workers.....	A	
Laborers:		
Compounding room.....	U	
Others	U	
2. Rubber Garment, Shoe, glove, etc., Making:		
Skilled workers.....	A	
3. Tire Manufacture:		
Tire builders, inspectors, repairmen, inner tube makers, cutters, curers (steam), and vulcanizers (steam).....	A	
4. Synthetic Rubber—Manufacture:		
Foremen	AA7	
Skilled workers.....	A	
Pipefitters	A†	
Laborers	U	
Safe and Machinery Movers:		
Chauffeurs	H & S	
Sand Pits.....	See Mining Industry	
Sandblasters:		
Building cleaners.....	U	
Others, generally		
Fully automatic.....	H & S	
Others	H & S	
Sandpaper Makers.....	A	
Saw and Planing Mills:		
Where logs are sawn:		
Tallymen, scalers, and graders.....	A†	
Foremen	A†	
Sawyers, carriage riders, planer feeders, saw filers, and other skilled workers.....	A†	
Lumber handlers, pliers, truckers, car loaders, and similar laborers	U	
Where no logs are sawn.....	See Woodworking	
Scavengers	U	
Scrubwomen	U	
Seamen:		
Merchant marine.....	See Marine Industry	
Navy and Coast Guard.....	See Military Services	

Occupation or Industry—Continued

Health
ins. class

Servants :

Hotels :

Male..... H & S

Female..... H & S

Domestic

Governess, maids, nursemaids..... H & S

Others..... H & S

Service Stations..... See Automobile Service

Sewer Department Employees :

Foremen..... A†

Inspectors..... A†

Skilled workers..... H & S

Laborers..... U

Sheet Metal Workers :

Roof or cornice work..... AE

Shop work only..... AA7

Sheriffs and Deputy Sheriffs..... See Police

Ship and Boat Building and Dry Docks :

1. Ship Construction :

Loft and shop :

Linesmen, loftsmen, pattern and template makers..... A

Machine shop workers..... See Machinists and Machine Shops

Hull :

Foremen..... AA7

Bolters-up, buckers-up, carpenters (rough), calkers, chippers

cranemen, drillers, holders-on, passers, plate hangers,

reamers, riveters, rivet heaters, ship-fitters..... A†

Painters; welders (burners, tackers)..... AE

Scalers..... H & S

Riggers, erectors, and hosemen..... H & S

Laborers..... U

Electricians..... See Electrical Industry—
usual ratings apply

Finishing operations such as painting and carpentry..... A†

2. Boat Building—Small Boats, Motor Boats, etc.

Foremen..... AA7

Calkers, carpenters, painters, plumbers, and similar skilled

occupations..... A†

Laborers..... U

Steel hull workers.....

3. Submarine Construction :

Civilian employees :

Making trial runs and dives.....

Others..... Rate as Ship Construction

Shockets (Kosher killing)..... A

Shoe Manufacturer :

Proprietors :

Superintending only..... AAA

Others..... AA7

Foremen..... AA7

Skilled workers..... A

Laborers..... U

Shoe Repairers, Cobblers..... A

Sign Hangers..... A†

Sign Painters :

In shop only..... A

Outside work..... AE

Silk Mills..... See Textile Industry

Silversmiths..... AA7

Slaughter and Packing Houses..... See Stockyards

Smelters..... See Metal Industries

Soap Manufacture :

Foremen..... AA7

Crutchers, cutters, packers, slabbers, and wrappers..... A

Kettle-men, mixers, drier-men, and other skilled process workers... A

Laborers..... U

Occupation or Industry—Continued

Health
ins. class

Social Service (welfare) Workers—Charitable, Religious, and Government :	
Administrators-----	AAAA
Case workers-----	AAA
Soft Drink Manufacture-----	See Beverage Industry (Non-Alcoholic)
Solderers (Except storage battery solderers)-----	A
Sports-----	See Amusements and Sports
Starch and Corn Products Manufacture :	
Foremen-----	AA7
Packaging and finishing operations workers-----	A
Other skilled workers-----	A
Laborers-----	U
Stationary Engineers :	
School and office buildings-----	AA
Others, generally-----	A†
Stationary Firemen, generally-----	A†
Steam and Power Shovel Operators :	
Building and construction-----	A†
Open pit mines and quarries-----	H & S
Steam Roller Operators-----	A†
Steamfitters-----	See Plumbers
Stereotypers-----	AA7
Stevedores-----	See Docks
Stewards-----	See Liquor and Allied Trades
Stockyards, Slaughter, and Packing Houses (See also Cold Storage) :	
Commission men, buyers, inspectors, and salesmen-----	AA
Shochets and shipping clerks-----	A
Foremen-----	A
Butchers, curers, labelers, sausage makers, smokers, skimmers, wrappers, and other skilled workers-----	A
Drivers, killers, knockers, and other skilled workers around live animals-----	U
Laborers-----	U
Stone Industry :	
Quarries-----	See Mining Industry
Concrete block makers :	
Foremen-----	A
Skilled workers-----	A†
Laborers-----	U
Crushed rock or stone for construction :	
Crushermen-----	H & S
Stone mills and yards :	
Granite :	
Foremen; polishers and cutters-----	H & S
Limestone—cutters-----	H & S
Marble :	
Foremen-----	A
Bed-rubbers and cutters-----	H & S
Monument shops :	
Proprietors or managers-----	AA
Carvers, cutters, letterers (carvers)-----	H & S
Sandblasters :	
Fully automatic-----	H & S
Others-----	H & S
Paving stone and sandstone—cutters-----	H & S
Laborers—all branches-----	U
Storage Battery Manufacture-----	See Electrical Industry
Street Cleaning and Garbage Collection :	
Foremen-----	AA7
Inspectors-----	AA
Chauffeurs-----	H & S
Garbagemen, sweepers, helpers, laborers-----	U

Occupation or Industry—Continued

Health
ins. class

Submarine:

Submarine service

Military Pay Grades E1-E3----- U

Military Pay Grades E4-E9, warrant and commissioned
officers----- U

Submarine construction—civilian employees

Making trial runs and dives-----

Others----- See Ship Construction

Subway Employees----- See Railroad Industry

Sugar Refineries:

Foremen----- AA7

Packaging and finishing operations workers----- A†

Other skilled workers----- U

Laborers----- A

Surveyors:

Building and construction, generally----- AAA

Railroad industry----- AA

Others, hazardous duties-----

Tailors:

High grade shops

Owners, supervisors, fitters----- AA7*

Other employees----- A

Usual grade shops—only occasionally dry cleaning

Owners and employees----- A

Tailors, clothing factories----- A

Tank Manufacture:

1. Tanks (For use in industry)

Erection----- See Building and Construction—
structural iron workers, carpenters, etc.

Fabrication----- See Boilermaking

2. Armored Cars and Tanks:

Hot metal and rolling processes. See Metal Industries

Fabrication processes:

Foremen----- AA7

Skilled workers----- A†

Welders:

Automatic machine (electric resistance—mechanical
pressure)----- A

Others (arc, gas, etc.)----- A†

Laborers----- U

Assembly and finishing processes

Foremen----- AA7

Skilled workers----- A

Laborers----- U

Tanneries:

Foremen----- AA7

Skilled workers in finishing processes, including buffers, spli-
cers, shavers, patchers, rollers, pebbles, grainers, splitters,
morocco stakers, blooders, seasoners, glazers----- ASkilled workers in the beaming house and tanning yard, table
hands, tackers, softeners----- A

Laborers----- U

Teachers, Instructors, Tutors, or Professors:

Academic subjects—teaching in classroom----- AAA

Vocational subjects—teaching by practical work (in laboratory,
shop, or field, etc.), generally----- AAA

Music:

School or college, not playing an instrument----- AAA

Others----- AA7

Athletic instructors—school or college----- AA7

Occupation or Industry—Continued

	Health ins. class
Teamsters -----	See Chauffeurs
Telegraph and Telephone:	
Line inspectors -----	A†
Foremen -----	AA7
Outside installers and repairmen, combination men, wiremen and other outside skilled workmen, not members of line crews, whose work on poles or in conduits is incidental to other duties_	A†
Linemen, conduitmen, troublemen (outside), cable splicers_	H & S
Groundmen; pole setters -----	H & S
Laborers -----	U
Tempering and Hardening -----	A†
Terra Cotta Manufacture -----	See Potteries
Textile Industry:	
Artificial silk (rayon)—preparation department_	See Artificial Silk
Asbestos products manufacture -----	See Asbestos Industry
Nylon—preparation department -----	See Nylon
Cotton, hemp, jute, mohair, silk, and wool mills; carpet, cordage, knitting, rope, rug mills; bleaching, dyeing, printing	
Proprietors, superintending only -----	AAA
Foremen, overseers -----	AA7
Section and second hands -----	A
Skilled operatives	
Opening and picking departments -----	H & S
Other departments -----	A
Laborers -----	U
Theaters -----	See Amusements and Sports
Ticket Collectors, Ferry or Railway Station -----	AA
Tile Manufacture -----	See Potteries
Tin Plate Mills -----	See Metal Industries
Tinners (Metal coaters) -----	A†
Tinsmiths:	
Roof or cornice work -----	AE
Others -----	AA7
Tire Manufacture -----	See Rubber and Rubber Products
Tobacco, Cigar, and Cigarette Manufacture	
Proprietors:	
Superintending only -----	AAA
Others -----	A
Foremen -----	AA7
Skilled workers -----	A
Laborers -----	U
Tool Makers, generally -----	AA7
Toxicologists -----	AAA
Tree Sprayers, Tree Surgeons -----	A†
Trucking Company Proprietors, superintending only, not driving truck -----	AA
Truck Drivers -----	See Chauffeurs
Truck Operators, Truckers:	
Hand trucks: -----	U
Electric trucks, generally -----	A†
Tunnel Construction -----	See Building and Construction
Type Founders -----	A
Undertakers and Embalmers:	
Undertakers, best grade -----	A*
Embalmers and assistance undertakers -----	A
Upholsterers:	
Proprietors, managers, and employees -----	AA7
Valets -----	H & S
Vending (Merchandise) Machines—Candy, cigarettes, clothing, soft drinks, etc. -----	3
(See Amusements and Sports for amusement machines):	
Wholesale and jobber:	
Owners, managers, salesmen:	
No delivering -----	AAA
Delivering -----	A†

Occupation or Industry—Continued

Health
ins. class

VENDING (Merchandise) MACHINES—Continued

Retail distribution and service:	
Owners, managers	
No delivering	AA7
Delivering	A†
Salesmen—not delivering	AA7
Collectors, salesmen (delivering), servicemen	A†
Veterinarians:	
Cats and dogs	AAA
Other animals	AA
Waiters and Waitresses:	
Beer, wine, or liquor served	See Liquor and Allied Trades
No beer, wine, or liquor served	
Waiters	H & S
Waitresses	H & S
Railroad club or dining car	
Waiters	H & S
Waitresses	H & S
Watchmen, generally	H & S
Welding and Cutting:	
Automatic machine (electric resistance—mechanical pressure)	A
All other processes (electric arc, gas, etc.):	
Metal mills, boiler and tank manufacture	A†
Oil and natural gas industry	
Shop work	A†
Field	H & S
Shipbuilding	AE
Bridge and structural iron and steel	H & S
Building wreckers	U
Railroads	
Roundhouse and shop	A†
Rail welders—all lines	H & S
Other industries, generally	A†
White Lead Makers:	
Foremen	H & S
Plumbers, pipefitters, steamfitters	A†
Skilled process workers	H & S
Laborers	U
Window Cleaners	H & S
Window Dressers or Trimmers (Retail stores):	
Liquor and allied trades	See Liquor and Allied Trades
Others	
Wineries	See Liquors and Allied Trades
Wire Drawers	A†
Wireless Operators:	
On land	A
On ships	See Marine Industry
Woodworking:	
Where logs are sawn	See Saw and Planing Mills
Where logs are not sawn	
Foremen	AA7
Carpenters and cabinet makers doing bench work only	A
Sanding machine, saw, and other machine operators	A†
Finishers, polishers, and sandpapers (hand); saw filers	A
Lumber handlers, pilers, truckers (hand), car loaders, and similar laborers	U

Occupation or Industry—Continued

Health
ins. class

Woolen and Worsted Mills.....	See Textile Industry
X-ray, Radium, and Radioisotopes :	
Medical and allied professions :	
Diagnostic X-ray, fluoroscopy, or skin therapy	
Physicians	AAA
Nurses	H & S
Technicians	AA
Radium and deep X-ray therapy	
Physicians	AAA
Nurses	H & S
Technicians	AA
Conducting research with radioisotopes :	
Physicists, technicians, etc.....	AAA
Industries :	
Radium preparation laboratories :	
Chemists, physicists, and technicians; emanation (ra-	
don) pumpmen, tube fillers and handlers.....	H & S
X-ray technicians.....	AA
X-ray machine installers and servicemen.....	A†
Radioisotopes, use of :	
Radiographic inspection, process control, leakage con-	
trol, etc.....	A
Radium dial manufacture :	
Spray process—all workers.....	U
Other processes :	
Dial painters, transfer press operators, dusters,	
paint mixers, weighers, inspectors, chemists, and	
laboratory workers.....	H & S
Laborers	U
Zinc Smelting and Refining.....	See Metal Industries

HEALTH INSURANCE MEDICAL IMPAIRMENT RATINGS

Applicants with certain medical impairments (listed below) may be offered one of the Hospital, Surgical and Medical Expense policies subject to an additional premium charge dependent on the severity of the impairment and the nature and history of the impairment. The additional premium will range from a minimum of 15% to a maximum of 75% of the basic premium and may be on a temporary or permanent basis. Coverage will be considered for the following types of impairments or disorders:

Overweight, High Blood Pressure, Diabetes.
Asthma, Bronchial and Certain Lung Diseases.
Digestive Diseases.
Certain Female Disorders.
Kidney Stone.

Low Back Sprains, Certain Histories of Arthritis.

Where such ratings are necessary, the applicant *will not be offered a restrictive rider* in place of the extra premium required for the impairment. However, in some instances such as histories involving stomach or certain female disorders, a restrictive rider will be required for a period of six months in addition to the extra premium. Also, in situations involving histories of diabetes and certain lung disorders, there will be a limitation as to the form and amount of coverage that will be available to these applicants.

Applicants who do not qualify for Life Insurance Standard rating because of overweight should be notified that there may be an extra premium charge according to the special rating determination that will be made by the Personal Health Underwriters. In a borderline case, the H.O. may request the MIC Manager or Agency Manager to verify the height and weight.

LIFE INSURANCE UNDERWEIGHT RATINGS—MEN

The weights shown below are the minimum allowed for each rating. Those shown for the ratings "No Restriction" are not average weights but in every case several pounds less than the average.

Height Ft. in.	Age						Rating tower series
	15 to 16	17 to 19	20 to 29	30 to 39	40 to 49	50 and over	
4-6-----	75	78	87	87	85	85	No restriction.
-----	-----	73	82	83	83	83	Preferred.
-----	66	69	76	79	80	81	Standard.
4-7-----	77	81	89	89	87	87	No restriction.
-----	-----	76	84	85	85	85	Preferred.
-----	86	72	78	81	82	83	Standard.
4-8-----	80	84	92	92	89	89	No restriction.
-----	-----	78	86	87	87	87	Preferred.
-----	70	74	80	83	84	85	Standard.
4-9-----	82	86	94	94	92	92	No restriction.
-----	-----	81	88	89	89	89	Preferred.
-----	72	77	82	85	86	87	Standard.
4-10-----	84	89	97	97	94	94	No restriction.
-----	-----	84	90	91	91	91	Preferred.
-----	74	79	84	87	88	89	Standard.
4-11-----	87	92	99	99	97	97	No restriction.
-----	-----	86	92	93	93	93	Preferred.
-----	76	81	86	89	90	91	Standard.
5-0-----	89	95	101	101	99	99	No restriction.
-----	-----	89	94	95	95	95	Preferred.
-----	78	83	88	91	92	93	Standard.
5-1-----	93	98	103	103	101	101	No restriction.
-----	-----	92	97	98	97	97	Preferred.
-----	81	86	91	94	94	95	Standard.
5-2-----	96	101	106	106	103	103	No restriction.
-----	-----	94	99	100	99	99	Preferred.
-----	84	88	93	96	96	97	Standard.
5-3-----	100	103	109	109	106	106	No restriction.
-----	-----	96	101	102	102	102	Preferred.
-----	87	90	95	98	98	99	Standard.
5-4-----	103	106	111	111	108	108	No restriction.
-----	-----	98	103	104	104	104	Preferred.
-----	90	92	97	100	100	101	Standard.
5-5-----	107	110	114	114	111	111	No restriction.
-----	-----	102	106	107	107	107	Preferred.
-----	93	96	100	103	103	104	Standard.
5-6-----	110	114	117	117	115	115	No restriction.
-----	-----	106	109	110	110	110	Preferred.
-----	96	99	103	106	106	107	Standard.
5-7-----	114	117	120	120	118	118	No restriction.
-----	-----	109	112	113	114	114	Preferred.
-----	99	103	106	109	109	110	Standard.
5-8-----	117	121	124	124	122	122	No restriction.
-----	-----	112	115	117	117	117	Preferred.
-----	102	106	109	112	112	113	Standard.
5-9-----	121	125	128	128	126	126	No restriction.
-----	-----	116	119	121	120	120	Preferred.
-----	106	110	113	115	115	116	Standard.
5-10-----	125	129	132	132	130	130	No restriction.
-----	-----	120	123	125	124	124	Preferred.
-----	109	113	116	118	118	120	Standard.
5-11-----	129	133	136	136	134	134	No restriction.
-----	-----	124	127	129	128	128	Preferred.
-----	113	116	119	122	122	123	Standard.
6-0-----	134	137	140	140	138	138	No restriction.
-----	-----	127	130	132	132	132	Preferred.
-----	117	120	122	125	125	127	Standard.
6-1-----	138	141	145	145	143	143	No restriction.
-----	-----	131	135	137	137	137	Preferred.
-----	120	123	126	130	130	132	Standard.
6-2-----	142	146	150	150	148	148	No restriction.
-----	-----	135	140	142	142	142	Preferred.
-----	124	127	130	135	135	137	Standard.
6-3-----	146	150	155	155	153	153	No restriction.
-----	-----	139	145	147	147	147	Preferred.
-----	127	131	134	140	140	142	Standard.
6-4-----	150	154	161	161	159	159	No restriction.
-----	-----	143	149	151	153	153	Preferred.
-----	131	135	138	143	145	147	Standard.

Women

The approximate underweight limits for women are obtained by deducting two inches from the height and entering the table.

LIFE INSURANCE OVERWEIGHT RATINGS—MEN

The weights shown below are the maximum allowed for each rating. Those shown for the ratings "no restriction" are not average weights but in every case several pounds in excess of average.

Height Ft., in.	Age						Rating tower series
	15 to 16	17 to 19	20 to 29	30 to 39	40 to 49	50 and over	
4-6-----	103	111	117	117	117	117	No restriction.
-----	132	124	132	129	125	125	Preferred.
-----	147	139	147	141	136	133	Standard.
4-7-----	107	156	168	160	156	154	Standard B.
-----	107	115	121	121	121	121	No restriction.
-----	136	128	136	133	129	129	Preferred.
-----	151	143	151	145	140	137	Standard.
4-8-----	111	160	172	164	160	158	Standard B.
-----	111	119	125	125	125	125	No restriction.
-----	140	132	140	137	133	133	Preferred.
-----	155	147	155	149	144	141	Standard.
4-9-----	115	164	175	168	164	162	Standard B.
-----	115	123	129	129	129	129	No restriction.
-----	144	136	144	141	137	137	Preferred.
-----	159	151	158	152	148	145	Standard.
4-10-----	119	168	179	171	168	166	Standard B.
-----	119	127	133	133	133	133	No restriction.
-----	147	140	148	145	141	141	Preferred.
-----	163	154	162	156	152	149	Standard.
4-11-----	123	172	183	175	172	170	Standard B.
-----	123	131	137	137	137	137	No restriction.
-----	151	144	152	149	145	145	Preferred.
-----	167	158	166	160	156	153	Standard.
5-0-----	127	176	187	179	176	174	Standard B.
-----	127	135	141	141	141	141	No restriction.
-----	155	148	156	153	149	149	Preferred.
-----	171	162	170	164	160	157	Standard.
5-1-----	132	180	190	183	180	178	Standard B.
-----	132	139	145	145	145	145	No restriction.
-----	160	152	160	157	153	153	Preferred.
-----	175	167	174	168	164	161	Standard.
5-2-----	136	184	194	188	185	183	Standard B.
-----	136	143	149	149	150	150	No restriction.
-----	165	156	164	161	158	158	Preferred.
-----	180	171	178	172	169	166	Standard.
5-3-----	141	188	198	192	190	188	Standard B.
-----	141	147	153	153	154	154	No restriction.
-----	170	160	168	165	162	162	Preferred.
-----	185	176	182	176	173	170	Standard.
5-4-----	145	193	202	197	194	192	Standard B.
-----	145	151	157	157	158	158	No restriction.
-----	176	165	172	169	166	166	Preferred.
-----	191	181	186	180	177	174	Standard.
5-5-----	150	198	206	201	199	197	Standard B.
-----	150	155	161	161	163	163	No restriction.
-----	181	169	177	174	171	171	Preferred.
-----	196	186	191	185	182	179	Standard.
5-6-----	154	203	211	206	205	203	Standard B.
-----	154	160	166	166	168	168	No restriction.
-----	186	173	183	179	177	177	Preferred.
-----	201	191	197	191	188	185	Standard.
5-7-----	159	208	217	212	211	209	Standard B.
-----	159	165	170	170	173	173	No restriction.
-----	191	177	187	184	182	182	Preferred.
-----	206	196	202	196	193	190	Standard.
5-8-----	163	213	222	217	217	215	Standard B.
-----	163	168	174	174	177	177	No restriction.
-----	196	182	192	183	187	187	Preferred.
-----	212	201	207	201	198	195	Standard.
5-9-----	169	219	227	222	222	220	Standard B.
-----	169	175	181	181	184	184	No restriction.
-----	202	188	199	195	194	194	Preferred.
-----	219	208	215	209	206	202	Standard.
5-10-----	173	226	235	231	231	229	Standard B.
-----	173	180	186	186	189	189	No restriction.
-----	207	193	205	200	199	199	Preferred.
-----	225	213	221	215	212	208	Standard.
5-11-----	178	232	242	238	238	236	Standard B.
-----	178	184	190	190	194	194	No restriction.
-----	212	198	210	205	204	204	Preferred.
-----	230	219	227	221	218	214	Standard.
6-0-----	183	237	247	244	244	243	Standard B.
-----	183	189	195	195	199	199	No restriction.
-----	219	203	215	210	209	209	Preferred.
-----	236	225	233	227	224	219	Standard.
-----	236	243	254	251	251	249	Standard B.

LIFE INSURANCE OVERWEIGHT RATINGS—MEN—Continued

Height Ft., in.	Age						Rating tower series
	15 to 16	17 to 19	20 to 29	30 to 39	40 to 49	50 and over	
6-1.....	188	194	200	200	205	205	No restriction.
	224	208	220	215	215	215	Preferred.
	241	230	238	232	230	225	Standard.
6-2.....	192	241	260	257	257	255	Standard B.
	219	199	206	206	211	211	No restriction.
	229	213	226	221	221	221	Preferred.
	247	235	244	238	236	231	Standard.
6-3.....	197	247	266	263	263	261	Standard B.
	218	204	212	212	217	217	No restriction.
	234	218	232	227	227	227	Preferred.
	252	241	250	244	243	238	Standard.
6-4.....	202	260	273	270	270	268	Standard B.
	224	210	217	217	223	223	No restriction.
	240	224	237	233	233	233	Preferred.
	258	247	255	249	249	244	Standard.
6-5.....	208	266	279	276	276	274	Standard B.
	230	215	223	223	230	230	No restriction.
	246	230	243	240	240	240	Preferred.
	264	253	261	255	256	251	Standard.
6-6.....	214	273	285	282	282	280	Standard B.
	221	221	229	229	236	236	No restriction.
	236	249	246	246	246	246	Preferred.
	252	259	267	261	261	257	Standard.
	270	279	291	288	288	286	Standard B.

Women

The approximate overweight limits for women are obtained as follows:
 If under age 40—deduct 2 inches from the height and enter the table.
 If age 40 or over—deduct 1 inch from the height and enter the table.

INDEX

PERSONAL HEALTH INSURANCE

LOSS-OF-TIME, TRAVEL-PLUS POLICIES

	Page
Acceptable Occupations with Classifications.....	HOR Pages
Acceptable Risks.....	HD13
Advance Payments.....	HD14
Application Form.....	HD13
Business Overhead Expense—Benefit G, V.I.P. Policy :	
Description	HD3, HD10
Rates	HR1—HR59
Career Woman's Disability Income Policy :	
Description	HD6, HD12
Rates	HR1—HR59
Claim Service—Notice, Examinations, Statement of Claim, Acciden- tal Death	HD15
Delivery of Policies.....	HD14
Doubtful Risks.....	HD13
First Day Accident Coverage—Available with Benefit B, V.I.P. Policy :	
Description	HD2, HD10
Rates	HR1—HR59
Guaranteed Insurability—Benefit E, V.I.P. Policy :	
Description	HD3, HD9
Rates	HR1—HR23
Hospital-Indemnity While In—Benefits D and F, V.I.P. Policy :	
Description	HD2, HD3, HD9, HD10
Rates	HR1—HR59
Indemnity (maximum) and Participation Limits.....	HD7
Lifetime Accident Coverage :	
Description	HD2, HD10
Rates	HR1—HR59
Limits (participation)	HD7
Maximum Weight Limits.....	HD14
Medical Examinations.....	HD14
Mercantile Reports.....	HD14

Minimum Premium -----	Page HD13
Monthly Indemnity for Total Disability—Benefit A and Benefit B, V.I.P. Policy :	
Description -----	HD2, HD9
Rates -----	HR1—HR59
Occupational Ratings -----	HOR Pages
Persons Previously Declined or Rated Up -----	HD13
Premium, Calculation of -----	HD15
Premium Rates -----	HR1—HR65
Principal Sum—Benefit C, V.I.P. Policy :	
Description -----	HD2, HD9
Rates -----	HR1—HR59
Prohibited Risks -----	HD13
Protector Disability Income Policy :	
Description -----	HD5, HD12
Rates -----	HR60—HR65
Residence and Travel Outside the U.S. and Can. -----	HD13
Simplex Disability Income Policy :	
Description -----	HD6, HD12
Rates -----	HR1—HR59
Simplex Disability Income Policy with Principal Sum Indemnity :	
Description -----	HD6, HD12
Rates -----	HR1—HR59
Travel-Plus :	
Description -----	HD4, See also Benefit C on page HD9
Rates -----	HR59
Underwriting Rules :	
Requirements and Limitations -----	HD8—HD12
Additional Rules and General Information -----	HD13—HD15
Versatile Income Protection Disability Policy	
Description -----	HD1—HD3, HD9, HD10
Rates -----	HR1—HR59

HOSPITAL, SURGICAL AND MEDICAL EXPENSE POLICIES

Acceptable Occupations with Classifications -----	HOR Pages
Acceptable Risks -----	HD32
Advance Payments -----	HD33
Amount Limits -----	HD33
Application Form -----	HD33
Claim Service—Notice, Statement of Claim -----	HD35
Comprehensive Medical Expense Policies :	
Description -----	HD16—HD18
Rates -----	HR70, HR71
Frequency of Premium Payment -----	HD33
In-Patient Policies and Optional Surgical Expense Rider :	
Description -----	HD21
Rates -----	HR76, HR77
In-Patient—Modified :	
Description and Rates -----	HD36
Instructions for Using the Tables of Rates -----	HD35
Major Medical Expense Policies :	
Description -----	HD22—HD24
Rates -----	HR78
Medical Examinations and Mercantile Reports -----	HD33
Modified In-Patient Policies :	
Description and Rates -----	HD36
Occupational Ratings -----	HOR Pages
Premium, Calculation of :	
Rated Areas (Florida, Louisiana, Mississippi, New Mexico, Pacific Coast, Tennessee, Texas) -----	HD34
Premium Rates -----	HR66—HR78
Rated Areas (Florida, Louisiana, Mississippi, New Mexico, Pacific Coast, Tennessee, Texas) -----	HD34

	Page
Radiotherapy Schedule-----	HD31
Risks Not Acceptable-----	HD32, HD33
Residence and Travel Outside the U.S. and Can-----	HD13
Surgical Operations Schedule-----	HD25-HD30
Standard Hospital and Surgical Expense Policies :	
Description -----	H416-HD18
Rates-----	HR66, HR67
Sterling Policies :	
Description -----	HD16-HD18
Rates -----	HR72, HR75
Surgical Expense Rider, Optional with In-Patient Policies-----	HD21
Tower Policies :	
Description-----	HD19, HD20
Rates-----	HR68, HR69
Underwriting Rules-----	HD32, HD33

HEARINGS ON COMMERCIAL HEALTH AND ACCIDENT INSURANCE INDUSTRY

WEDNESDAY, JUNE 7, 1972

U.S. SENATE,
SUBCOMMITTEE ON ANTITRUST AND MONOPOLY,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met at 10 a.m., in room 2228, New Senate Office Building, Senator Philip A. Hart presiding.

Present: Senator Philip A. Hart.

Also present: Howard O'Leary, chief counsel; Peter N. Chumbris, minority counsel; Charles Kern, staff of Senator Fong; Dean E. Sharp, counsel; Patricia Bario, editorial director; and Janice William, clerk.

Senator HART. The committee will be in order.

We will hear first this morning from Dr. Milton Roemer, professor of public health at UCLA.

Doctor, we welcome you. You have a prepared statement and we will order it printed in full in the record as given. As you go along, if there are any additions you want to make, feel free to do it.

STATEMENT OF DR. MILTON I. ROEMER, PROFESSOR OF HEALTH ADMINISTRATION AT THE SCHOOL OF PUBLIC HEALTH OF THE UNIVERSITY OF CALIFORNIA, LOS ANGELES, AND PROFESSOR OF PREVENTIVE AND SOCIAL MEDICINE AT THE UCLA MEDICAL SCHOOL

Dr. ROEMER. Thank you, Mr. Chairman. I have a relatively brief statement I would like to present to the committee.

I am Milton Roemer, professor of health administration at the School of Public Health of the University of California, Los Angeles, and professor of preventive and social medicine at the UCLA Medical School.

I have been in this and other university posts (Yale and Cornell) for some 16 years, before which I served in the U.S. Public Health Service and other public positions for some 15 years.

Thus, since earning my medical degree in 1940, I have been engaged full time in practice, study, or teaching about problems relating to the organization or administration of health services.

Since coming to UCLA in 1962, my colleagues¹ and I have been

¹ Carl E. Hopkins, Ph. D., Robert W. Wetherington, Ph. D., Arthur R. Gerst, Eleanor Parsons, and Donald M. Long.

involved in several studies on the operation of various health insurance plans. Most important of these has been a comparative analysis of the principal features and effects of the three main types of health insurance program that are operating in the United States.

This research has been supported by a series of grants from the U.S. Department of Health, Education, and Welfare, amounting over the last 7 years to about \$700,000.

In response to your invitation, Mr. Chairman, I am pleased to present to your subcommittee on Antitrust and Monopoly some of the highlights of our findings from this research.

I hope that these findings may have some relevance for your deliberations, to quote from your letter, on "the commercial health insurance industry and its overall role in helping to develop a health-care system responsive to the needs of consumers."

The three principal types of health insurance programs operating in our country today, as you know, are, in order of their enrollment size, those sponsored by commercial insurance companies; secondly, by providers of health care—mainly the medical and hospital associations (symbolized commonly as Blue Cross and Blue Shield plans); and thirdly, consumers, by employers or other groups applying the pattern of prepaid group medical practice. The third of these types have recently come to be called "health maintenance organizations", or "HMO's."

It is of some interest that historically the development of these programs has been in the reverse order from that just given—that is, the consumer-sponsored plans being oldest, the provider-sponsored plans coming next, and the commercial plans being newest.

The market dynamics of sales in the insurance field, however, has resulted in a situation where currently the largest share of the market is held by the commercial insurance companies, followed by the other two types of plans as stated.

To simplify my summary of our principal research findings, I shall refer to these three types of health insurance programs as commercial plans, provider plans, and group practice plans.

It would be tedious, Mr. Chairman, to explain the detailed methodology of this research, but let me simply indicate that our main strategy was to study the experience and attitudes of representative samples of the persons or families enrolled in each of these three types of plans.

To heighten the reliability of our findings, we investigated two examples (believed to be typical) of each of the three plan-types in California, and in each of these six organizations we studied the experience of 300 to 600—usually 600—enrolled family units.

These samples were randomly chosen with the greatest of care to assure representativeness and to eliminate any bias, so that we are confident of the validity of our findings.

Our information was collected in 1967 and 1968.

I would like to summarize our principal findings under five headings: first, composition of plan memberships; second, utilization of hospital and doctor services; third, technical content of services provided; fourth, expenditures incurred; and fifth, attitudes of plan members.

Information on these features was gathered through various methods, including carefully designed questionnaires, household interviews, analysis of actual medical records, interviews of health plan administrators and doctors, and examination of the insurance policies, or benefit-packages, themselves.

On the latter point, I cannot take time to describe the various complex provisions of the diverse offerings, but I can state that in each of the three plan-types, the benefit-packages are believed to be representative of those offered to group enrollees as a whole.

We did not study individual enrollment coverage, which is generally more restrictive and expensive.

COMPOSITION OF PLAN MEMBERSHIPS

As to composition of plan memberships, it is well known that the sickness experience of a population, and therefore its demands for medical care, will be influenced by its demographic and background characteristics.

If an insurance organization can selectively enroll persons with lower risks of illness, it will probably have fewer claims to pay. Evidence of risk is reflected in such factors as age level, previous chronic illness, and the individual's inherent sensitivity to the symptoms of disease.

The severity of illness tends to increase with age. In our study the age level of the persons enrolled in the three types of plans was found to be as follows:

In the commercial plans, it was 31.7 years; in the provider plans, 34 years; and in the group practice plans, 34 years.

Considering just the persons in the older age brackets, when illness rates are heaviest, we found these proportions:

Tabulating with the people who were 41 years of age or over, the percentage in that bracket for commercial plans was 24.6 percent; in the provider plans, 33.8 percent; in the group practice plans, 35.9 percent.

Thus, by either of these measures, the commercial plans are found to have enrollees of the youngest age levels, compared with the other two plan types. The group practice plan appears to have the highest risk members, as reflected by age level.

With respect to a past history of chronic illness of some sort in the family, in anyone in the family, our data showed the following percentages:

In the commercial plans, 62.6 percent of the families had no history of chronic illness, and 37.4 percent had. In the provider plans, 53.4 percent had no history of chronic illness, and, conversely, 46.6 percent had. In the group practice plans, 39.4 percent had no chronic illness and 60.6 percent had one or more chronic illnesses.

Even for bouts of acute illness in the most recent 3-month period, we found that these had occurred in 17.1 percent of commercial plan families, compared with 23.4 and 25.3 percent of families in the other two plan-types.

A third reflection of risk composition is a measure we have defined as symptom sensitivity—that is, the tendency of an individual with a given problem to seek medical attention for it. Interpretation of this

characteristic is admittedly complex, but our basic findings, in percentages, were that the commercial plans had 36.1 percent of the less sensitive people, 63.9 percent of the more sensitive.

The provider plans, however, had 33.7 percent of the less sensitive people, and 66.3 percent of the more sensitive; the group practice plans had 29.0 percent of the less sensitive people, and 71 percent of the more sensitive.

Thus, by all three measures of sickness risk, our findings indicate that the commercial companies have the lowest proportion of high-risk persons. The group practice plans have the highest proportion, with the provider-sponsored plans falling in between.

The sales or marketing practices that have resulted in this situation, Mr. Chairman, are beyond my competence to explain, but the social implications are clear to anyone; namely, the responsibilities for people with the highest burden of medical need are being borne by the commercial insurance carriers, the next level by the provider-sponsored plans, and the responsibilities for the heaviest burden of need are being borne by the group practice plans.

UTILIZATION OF HOSPITAL AND MEDICAL SERVICES

The payoff of risk-selection practices might be expected to show up in the rates of utilization of services by persons enrolled in the different types of health insurance program. These utilization rates, moreover, would naturally be influenced by two other factors: the precise benefit packages or coverage by the insurance policies, and second, the pattern of medical practice and remuneration of the doctors, insofar as these may or may not create incentives toward hospitalizing patients. Keeping all these influences in mind, our basic findings on hospital admission rates were as follows:

Commercial plans had admission rates of 102 admissions per thousand persons covered per year; the provider plans, 150 admissions per thousand per year; the group practice plans, 107 per thousand per year.

With respect to the aggregate days of hospitalization which counts most in determining the high cost of modern hospital care, our findings were that the commercial plans had 864 hospital days per thousand per year; the provider plans, 409, and the group practice plans 526 days per thousand persons per year.

Thus, it is clear that the provider-sponsored health insurance plans show the highest rate of both hospital admissions and hospital days.

The group practice plans, despite their heavier load of high-risk enrollees, have a hospital admission rate very close to that of the commercial plans, but much the lowest rate of aggregate hospital days.

Explanation for this is probably to be found partly in the medical incentive system operating in the salaried group practice or the HMO-type plans, and partly in the convenient access to ambulatory care in those plans.

I might add that we have made analyses of these hospitalization data, according to various types of families, large and small, various social class and income groupings, et cetera.

The basic relationships reported above tend to prevail in all of these breakdowns; the lesser rate of hospital days in the commercial, compared with the provider plans, however, is found to be attributable

mainly to the experience of lower social class families (that is, defining social class by a composite measure of occupation and educational background of the family heads).

As for ambulatory doctor's care, the experience of persons enrolled in the three plan-types was found to be as follows:

Commercial plans, for their members showed 3,108 doctor visits per thousand persons per year; provider plans, 3,984 per thousand per year; group practice plan, 3,324 per thousand per year.

Thus, once again, we see the lowest rate of ambulatory medical services in the enrollees of the commercial plans. It should be realized that most patient-doctor contacts beyond the initial office visit are decided upon by the doctor, but the first contact must be initiated by the patient. In the light of this, it is interesting to note our findings on the percentage of families that had no doctor visits in a recent 3-month period.

In this respect we found that in the commercial plans, the percentage with no doctor contacts in a recent 3-month period was 49.6 percent; in the provider plans, 36.1 percent; and in the group practice plans, 33.4 percent.

The fact that roughly half of the commercial plan families saw no doctor at all in this time period, compared with much lower percentages in the other plan-types, seems to confirm the evidence reported earlier about risk selection, as well as to reflect something about the restricted benefit offerings in the commercial plans.

TECHNICAL CONTENT OF SERVICES PROVIDED

Analysis of the technical content of medical services actually rendered under the different plan-types was a complex process, and I should like to report, Mr. Chairman, only two of our principal findings.

Without elaborate explanation of our methodology, we applied certain "value units" to each type of medical service rendered, based upon a well-known "relative value study", sometimes called a "relative value schedule", done by the California Medical Association.

Through this process, we calculated a "doctor's care index" per person per year for the subscribers to each of the three plan-types. These results were as follows:

For the commercial plans, the doctor's care index per person per year was 71.6; for the provider plans, 121.6; for the group practice plans, 87.9.

The low index of services furnished under the commercial plans is evident from these figures, in back of which are literally thousands—it was actually about 12,000—pieces of information derived from the study of actual medical records.

As for the comparative indexes of the provider-sponsored compared with the group practice plans, it should be realized that the very low rate of hospital days under the group practice plans would substantially influence this measurement of doctor services, since it included doctor services given at any location—that is the office, the home, or the hospital.

The second finding, I should—

Senator HART. Doctor, I apologize, but I am going to have to interrupt at least twice in the next hour. Rollcalls will occur on the floor. One has just been signaled.

We will recess, I would estimate, for about 15 minutes.

(Whereupon, a short recess was taken.)

Senator HART. We will be in order again.

Dr. ROEMER. Thank you, Mr. Chairman.

I was commenting on the technical content of services provided under the different types of insurance program.

The second finding I would like to report to the committee concerns the provision of preventive health services. In our detailed study of medical records, we identified those services which could be considered as probably preventive in purpose—such services as well-child examinations, annual checkup of adults, vaginal cytology tests, or Pap smears, routine rectal examinations, and immunizations.

Summating these items, we derived a measure of preventive service for each type of plan, and these were found to be as follows:

The commercial plans had a measure—in the written text the word “index” should be inserted, “preventive service index per person per year”—or an index of 0.384 per person per year; the provider plans, 0.404; and the group practice plans, 0.452.

While the record of preventive service is not impressively high now in any of the plans, it is clearly highest in the group practice plans and lowest in the plans sponsored by commercial companies.

EXPENDITURES INCURRED

Another important reflection of the operational effects of different types of health insurance plan is the expenditures incurred by families.

These are of two types: The premiums levied, which may be paid partly or wholly by employers, and secondly, the out-of-pocket expenditures of persons for medical care.

The latter may be referable to the expense of deductibles copayment charges, et cetera, or to the costs of services not covered at all under an insurance policy.

Our data on this question apply to expenditures for hospital and physician services, not to family expenses for medications, dental care, or other types of services, and they apply to expenditures during 1 year.

The basic findings for family units in the three types of insurance program were as follows:

In the commercial plans, the average premium was \$208; out-of-pocket expenditures, \$156; the total cost was \$364. In the provider plans, premium, \$257; out-of-pocket, \$190; total cost, \$447. In the group practice plans, average premiums, \$271; out-of-pocket expenditures, \$52; total cost of \$323.

These figures, I believe, tell us a great deal about the cost implications of the three types of health insurance plans. Their interpretation should not be oversimplified, for many factors are involved, but it would seem to be essentially as follows:

The commercial plans have the lowest average premiums, which probably go along with their strategies for enrollment of low-risk populations, that is, populations with low risks of sickness, and extensive application of cost-sharing requirements.

The group practice plans, with their higher risk subscribers, more comprehensive medical benefits, and very modest cost-sharing features,

have the highest premiums. The provider-sponsored plan premiums fall in between.

Out-of-pocket expenditures, on the other hand, are clearly lowest in the group practice plans. They are relatively high in both commercial and the provider plans, but highest in the latter which, as we saw, have the highest rates of both hospitalization and ambulatory care.

The aggregate or total costs, summing premiums and out-of-pocket expenditures for hospital and physician's care, are the major issue of social concern. These, we see, are highest in the provider-sponsored plans, next highest in the commercial plans, and lowest in the group practice plans.

These findings would seem to provide further support for the soundness of the idea of "health maintenance organizations" based on patterns of group medical practice.

Our expenditure findings have also been analyzed according to size-of-family, past illness history and other characteristics. Without troubling you with recitation of all these statistics, I can report that the lower overall costs of the group practice plans, compared with the other two types, applies to most of the subgroups.

As a crude approach to a cost-benefit analysis of the three types of health insurance plans, one may relate these total cost amounts to the aggregate "doctor's care index" figures which I reported earlier, insofar as these figures reflect medical services to both ambulatory and hospitalized patients.

Such a calculation makes no judgment on the medical necessity of various events, such as hospitalizations, but only on the ratio of total dollars spent, or cost, to the total doctor's care given, or benefits.

This calculation comes out as follows: The commercial plans with total costs of \$364, and doctor's care index of 71.6, have a cost-benefit ratio of 5.1.

The provider plans' arithmetic comes to a cost-benefit ratio of 3.7, and in the group practice plans, the ratio comes out to 3.7.

By this analysis, the cost per unit of medical value in the commercial insurance plans is found to be substantially higher than in the other two plan-types.

ATTITUDES OF PLAN MEMBERS

A final measurement of the effects of different types of health insurance is the attitudes of subscribers toward their plan. Our study solicited these attitudes along two dimensions. First, attitudes toward the medical care received; secondly, attitudes toward the financial protection offered by the plan.

We asked subscribers to record their feelings by checking an eight-point-scale, ranging from "highly satisfied" to "highly dissatisfied."

With respect to the medical care received, one must keep in mind that both the commercial and the provider plans allow the subscriber free choice of doctors, who are generally in solo medical practice.

The group practice plans require persons to use a specific organized clinic for their care. To listen to hostile critics of the latter arrangement, one might expect to find massive dissatisfaction among the families served by the group practice plans.

In fact, our findings for the subscribers to the three plan-types, expressed as percentages, were as follows:

The commercial plans, very satisfied, 46.5 percent; moderately satisfied, 36.2 percent; dissatisfied, 17.4 percent.

The provider plans, 44.9 percent very satisfied; 34.8 percent moderately satisfied; 20.3 percent dissatisfied.

Group practice plans, 42.6 percent very satisfactory; 49.3 percent moderately satisfied, and 8.2 percent dissatisfied.

Thus it would seem that in spite of the departure from customary and traditional medical care delivery patterns, the group practice plan members show only a slightly lower proportion of high satisfaction with their care than do persons in the free choice or open-market type of plan.

Moderate satisfaction is substantially stronger in the group practice plans. Most interesting is the substantially lower proportion of frankly dissatisfied persons in the group practice plans—less than half the percentages found in the commercial or provider plans.

When analyzed by the various social subgroups, these findings continue generally to prevail.

One interesting sidelight, however, is the record of satisfaction among single persons of each sex. Focusing on the extreme poles of high satisfaction versus dissatisfaction in the three types of insurance plans, we find the following:

For men, highly satisfied in the commercial plans, 38.4 percent; and dissatisfied, 36.4 percent. Provider plans, 39.4 percent very satisfied, and 32 percent dissatisfied. The group practice plans, very satisfied 65.1 percent, and dissatisfied only 7.8 percent.

For women, very satisfied with the commercial plans, 52.5 percent; dissatisfied, 18.7 percent; provider plans, 45.3 percent very satisfied; 13 percent dissatisfied. Group plans, 45.7 percent very satisfied; dissatisfied, 12.6 percent.

Perhaps there is a lesson in these findings for the management, Mr. Chairman, of group practice plans, with respect to women.

Or, perhaps, if Henry Higgins', of *My Fair Lady*, plea, "Why can't a woman be more like a man?", were generally heeded, then the group practice plans might show not only the lowest level of dissatisfaction, but also the highest level of top satisfaction as well.

Another barometer of consumer satisfaction, especially meaningful for the group practice plans, is the percentage of medical services procured outside of these organizations.

To listen to hostile medical critics, one might expect that large proportions of the members of these plans go elsewhere for their medical care, even though this means that they must pay privately.

Our findings, however, indicate that in the families insured by the group practice plans, only 12 percent of the specific medical services over the course of a year were obtained outside of the framework of the plan.

For hospitalizations, the out-of-plan cases were only 7.2 percent of the total.

By contrast, in the families insured through commercial carriers, for one reason or another, such as exclusions of certain types of diagnosis, waiting periods for maternity, et cetera, the hospitalizations not financed by the plan in 1 year amounted to 29.1 percent.

Concerning attitudes of subscribers toward the financial coverage offered by each of the plan-types, the findings of our study were clear cut.

Expressed as percentages, these were as follows:

The commercial plans, very satisfied, 36.5 percent; moderately, 3 percent; dissatisfied, 24.6 percent.

Provider plans, very satisfied, 28.1 percent; moderately satisfied, 37.1 percent; dissatisfied, 34.8 percent.

The group practice plans, very satisfied, 65.1 percent; moderately satisfied, 26.3 percent; dissatisfied, 8.6 percent.

Obviously, there is an overwhelmingly greater degree of high satisfaction with the financial protection offered by the group practice plans, and much less dissatisfaction, in spite of the higher premiums required, as you noted, for enrollment in those plans.

Between the two open-market plan-types, the financial protection offered by the provider plans elicits less satisfaction than that offered by the commercial plans. But one must recall the selectivity of enrollee risks in these plan-types.

Moreover, it should be pointed out that competition from commercial carriers has forced most of the provider-sponsored (that is, the Blue Cross and Blue Shield program) plans in the United States to introduce indemnification and cost-sharing features, which those plans initially lacked, and which tend to be irritating to many consumers.

Analyzed by various social subgroups, the levels of satisfaction just reported prevail generally for all categories. Considering the attitudes of persons in different social classes, however, the proportions of dissatisfaction are highest among lower class families in the provider plans, and among upper class families in the commercial plans.

SUMMARY

In summary, Mr. Chairman, our research on the operations of different types of health insurance plans indicates that the commercial carriers have enrolled persons of a lower level of sickness risk than the provider-sponsored (that is, Blue Cross and Blue Shield) plans, or the HMO-type plans based on group medical practice.

The latter plans are serving higher proportions of people with greater sickness needs. The rate of hospital days per thousand persons per year is highest in the provider plans, and by far lowest in the group practice plans.

Ambulatory medical service rates are relatively similar in all three plan-types, but are highest in the provider plans, next in the group practice plans, and lowest in the commercial plans.

Among the three plan types, the lowest index of doctor's care, by an aggregate measure, is also in the commercial plans, as is the lowest rate of preventive health services.

As for expenditures by families for hospital and physician's care, much the lowest out-of-pocket outlays are made by subscribers to the group practice plans.

For their more comprehensive benefits, these plans charge higher premiums, but considering total costs, that is the sum of premiums and personal outlays, those in the group practice plans are lowest and in the provider plans are highest.

When total costs are related to an aggregated measure of in-hospital and out-of-hospital doctor's care, however, the commercial plans show the costliest ratio.

The attitudes of insured persons toward medical care received under each type of plan show much less dissatisfaction in the group practice plans, despite their departure from conventional delivery patterns.

With respect to the financial protection offered by each plan type, the level of consumer satisfaction is overwhelmingly strongest for the group practice plans.

As between the two open-market free choice types of insurance organization, consumer satisfaction is somewhat lower for the provider sponsored than for the commercial plans.

If these organizations, however, wished to tailor their offerings to consumer wishes, as they frequently claim, it would seem appropriate for them to offer more comprehensive benefits than they now do.

I appreciate the opportunity, Mr. Chairman, to present these research findings to your subcommittee, and I hope that they may help in your evaluation of the complex variety of health insurance programs now operating in the United States.

Thank you, sir.

Senator HART. Doctor, thank you. The good fortune is ours. I just have no doubt that in the debate which is already in the preliminary stage, your massive studies, as I understand them to be, will be consulted by a great many people in determining what the society really should do about delivering health care and preventing sickness and illness.

It is my understanding that your statement is a summary of that soon-to-be-unveiled massive studies.

Dr. ROEMER. Yes, sir. It is a very brief summary of the highlights of a study which in full text would be several hundred pages long.

Senator HART. When can we expect to have that in the public's hands?

Dr. ROEMER. A somewhat more detailed summary of approximately 80 or 90 pages will be available in 2 or 3 weeks. We are in negotiation at the moment for its publication with the National Center for Health Services Research and Development which did most of the financing of this research.

Senator HART. You can be sure that this subcommittee along with a great many others here on the Hill will attempt to analyze that study just as soon as it is published.

I had hoped that we would not have to hold you, but I fear that we shall. There is another vote, and time is running out on the rollcall.

We will recess for about 15 minutes.

(Whereupon, a short recess was taken.)

Senator HART. The committee will be in order.

Doctor, I would like to ask for clarification from you on one point, and it is raised by material on page 8 of your statement.

You tell us that in a 3-month period of study about half again as many persons insured under commercial plans saw no doctors, compared with persons under provider or group plans.

Dr. ROEMER. Yes, sir.

Senator HART. What does that suggest—put in more direct terms than you put in your statement? Does it suggest, for example, that the deductible that is normally present in commercial plans, acts as a deterrent to an individual seeking early attention for potential medical problems?

Dr. ROEMER. We can only speculate on what it really means, sir. But as stated here, we think that it probably reflects the selection of persons with less risk of illness in the first place in the commercial plans, and also the effect of deductibles and the effect simply of noncoverage of ambulatory visits.

They are simply not a benefit in many of the plans, so that the patient would have to pay for the total cost.

Senator HART. Well, your answer is regarded as a professional one. Mr. Sharp?

Mr. SHARP. Thank you, Senator.

Dr. Roemer, do you feel that ways must be found to eliminate financial and other barriers to patients seeking early comprehensive medical treatment?

Dr. ROEMER. Yes. I believe that in the interest of health, we should put no barrier, in the form of deductibles or copayment charges, in the life of the patient that would retard or inhibit his seeking early medical care.

The one place that I would least like to see barriers is on the person's decision for the initial office visit, or initial contact with the doctor. That is where we would like the path to be most free and open.

I say this from the point of view of health promotion, of preventive medicine, and so on.

Mr. SHARP. Do you feel that it is the doctor, or the patient, who controls the utilization of medical facilities and their cost?

Dr. ROEMER. If we divide medical costs into two categories—those that are generated by the decision of the patient, and those that are generated by the decision of the doctor, my estimate would be that roughly 85 percent of the cost of medical care in the United States is determined by the decision of the doctor and perhaps 15 percent by the decision of the patient.

In other words, the patient's decision leads to the initial office contact. As for subsequent contacts, most—I would not say all, but most of them are determined by the doctor.

Laboratory and X-ray tests are determined by the doctor. Prescribed drugs are determined by the doctor. Hospitalization, which is the costliest element in medical care, is determined by the doctor.

Surgery is determined by the doctor. Physical therapy, et cetera.

So that most of the costs of medical care are determined by the doctor, and deterrents placed on the patient from that point of view simply don't make sense.

Mr. SHARP. As to the 15 percent of the costs that are determined by the patients initial office contact, do you feel that deductibles, coinsurance, waiting periods, and other devices of the indemnification commercial insurance system inhibit or act as a disincentive to early comprehensive medical treatment?

Dr. ROEMER. A good deal of study has been done on this point, Mr. Sharp. The evidence is complex—you can't summarize it in a yes or no manner.

If a cost-sharing requirement is trivial, such as perhaps \$1 a visit, or something of this sort, which has indeed been tested in Canada, the effect upon utilization is very slight. In fact, most of the evidence suggests that there may be a slight dip in utilization if there is a small cost-sharing requirement, but the curve in utilization soon rises again to the previous level before the minor cost-sharing was imposed.

On the other hand, if there is a substantial cost-sharing requirement, such as 20 percent of costs, the evidence is that it will deter utilization.

Now, whether it deters the so-called unnecessary utilization, we do not know. The evidence suggests that while a substantial cost-sharing requirement, such as 20 percent of the cost will deter utilization, there is no reason to believe that it will selectively deter the unnecessary utilization and not the necessary.

Indeed, although I have struggled with this problem for many years, I don't know what the definition of "unnecessary utilization" is. The patient may have a symptom which is psychologically generated, but to him it is a real problem.

The main decision on medical care, it seems to me, should be made by the doctor and one should not pass the buck to the patient, through a dollar sign, to deter his making a decision on utilization. This ought to be the doctor's decision.

MR. SHARP. We had some testimony earlier in these hearings to the effect that one method of controlling health care provide costs, that is, doctors and hospitals, would be for the private commercial health insurance companies—my understanding is that there may be as many as 1,200 of them in this country—to enter into individual contracts with each doctor and each hospital?

Do you have any thoughts as to the feasibility of such an arrangement?

DR. ROEMER. That such contracts might monitor unnecessary use?

MR. SHARP. Monitor control of costs, and also get into this quality aspect. Do you think that this would be feasible or practical, and that it would get the job done?

DR. ROEMER. I would answer that, Mr. Sharp, in two ways.

One is to look to past experience, with the monitoring process by insurance companies, or even indeed by Blue Cross and Blue Shield plans; the evidence is not very impressive, with respect to monitoring utilization.

I had occasion to serve as a consultant to the General Accounting Office about a year ago with respect to the monitoring of medical utilization under medicare, title 18, part B. I gather that this report has not yet been released, but I can say in a very general way, that the evidence of monitoring by the fiscal intermediaries was rather poor.

There was very little effective monitoring of so-called unnecessary medical services by the fiscal intermediaries, which are indeed, the provider plans and the commercial plans.

Now, the second way I would answer the question is that theoretically it might be possible to have an enormously elaborate and detailed monitoring system, but I doubt if the effort would be worth the cost.

There would have to be so much policing; so much looking over the shoulder and probing of the practices of individual doctors, that you would have more inspectors than doctors, and it would be an odious system.

So that I would say in general that it—the proposal you mention—does not strike me as practical.

Mr. SHARP. You mentioned, of course, that both the commercial health insurers and the Blue Cross-Blue Shield plans, are fiscal intermediaries—middlemen.

Would it be a fair statement to say as middlemen they do not like to get into controversy between the doctors and patients—patients are, after all—

Dr. ROEMER. Yes. I perhaps should have mentioned, in connection with my GAO observations, that an element in the relationship of the insurance companies to the doctors is an element of, "Let's not rock the boat. We want to maintain amicable relations with the medical profession."

One sees over the years the same attitude by the Blue Cross plans with respect to hospitals. "These are our friends. We do not wish to disturb them," and in order to avoid hostility or controversy, and also in order to avoid the sweat of litigations, and the nuisance of probing and visiting hospitals or doctors' offices to inspect records—in order to stay out of all this uncomfortable business, the tendency is not to monitor the hospitals or doctors with a firm hand, but to be rather cavalier in the relationship.

Mr. SHARP. Just one last point I would like to develop briefly with you, doctor. Your statement indicates quite clearly that as far as competition in the health marketplace is concerned, we have three basic types of programs.

Apparently from your statement, the consumer seems to be making out a little better with the prepaid group practice plan.

Now, do you see any hazards of the profit motive entering into the HMO's. What do you see ahead? What do you see happening in 10 or 15 years?

We had testimony yesterday from the Metropolitan Life Insurance Co., that they are attempting to market as an alternative to group insurance, a prepaid group practice, and figure out ways to make it competitively acceptable to the consumer with the traditional group insurance program, which is cost-plus-fee-for-service indemnification.

If this becomes prevalent in the marketplace, and many of the insurance companies are now thinking of entering into the field of health maintenance organizations, what do you see as the implications of this type of competition as far as the patient and consumer of health services is concerned?

Dr. ROEMER. The proposal has been made from a number of sources that, as I understand it—the concept of the HMO's should be one that would be promotable by profitmaking entities as well as nonprofit.

As the chairman of a subcommittee of the American Public Health Association, to tackle this very question, I had the occasion to give it a good deal of thought.

I would say that there are serious hazards in any health maintenance organization promotion, but particularly with respect to profit motives.

One principal hazard, as I see it, of health maintenance organizations, is the hazard of distorted selection of sickness risks—that is, a possibility that a particular HMO would selectively enroll people of low illness risk, and thus make a large profit.

Secondly, there is the hazard of underservicing, which is sometimes put in terms of the hazard of poor quality.

Both of these hazards I would anticipate would be particularly serious with respect to profitmaking entities. The evidence from our own studies has shown that the profit motive seems to be associated with enrollment of persons of lower sickness risk in the profitmaking insurance entities.

It is also associated with underservicing with respect to certain types of health service.

In the HMO pattern, there has been some merit attributed to the lower use of hospitals by members of such plans, but this could be overdone. It could be seriously overdone if the profit motive led to underservicing for laboratory tests, et cetera. There might be use of less expensive, but perhaps less effective drugs, and so on.

Now, all this could be controlled if there were enough monitoring. Theoretically, any type of organization ought to be free to operate in a free society, if there were enough control over abuses, or potential abuses.

But I think that the monitoring machinery would have to be so enormous to control, to limit, these abuses that it would get to be very top heavy. It would get to be offensive.

As a result, I think a wiser policy is to promote HMO's but without the profit motive. This was the position, in fact, that the American Public Health Association took in responding to this issue. Of course, I fully agree with this position.

Mr. SHARP. Would there be an analogy here also to what some have said concerning the proprietary hospital versus the nonproprietary hospital? Is there an analogy here?

Would you have in the marketplace the same type of competition as between the proprietary hospital and nonproprietary? Do you arrive at the same results with the for profit HMO's?

Dr. ROEMER. Well, if we look at the operation of the profit motive in general, on the basis of past experience in the health service system of the United States, the profitmaking entities stand out rather poorly, as far as meeting human needs, compared with the nonprofit entities.

Proprietary hospitals are example No. 1. Another piece of our own research at UCLA was just published last year by the Johns Hopkins Press—a book entitled "Doctors in Hospitals."

It was an analysis of the medical staff procedures and controls over quality in different types of hospitals, and in that study, we examined proprietary hospitals, compared with voluntary nonprofit hospitals, compared with Government hospitals.

There was simply no comparison. The findings were that quality promotion elements were enormously stronger in the nonprofit hospitals and in Government hospitals, compared with the proprietary ones.

The experience of nursing homes under proprietary ownership, as compared with nursing homes under religious and other nonprofit groups is equally dramatic. The existence of rehabilitation facilities, activity programs, and so on in the nonprofit entities is enormously better.

The Congress of the United States has had many hearings, I believe, on the nursing home industry, and the evidence of poor quality service in the thousands of proprietary nursing homes in this country is rather overwhelming.

Then there is the private drug industry for which there have also been Senate hearings not many years ago. In fact, these led to the drug control legislation of the early 1960's to monitor the influence of profit in the drug industry. These hearings told an impressive tale of the wastefulness that the consumer ultimately pays for, caused by the profit objective of the drug industry.

There may be some benefits from drug company profit motives, but it seems to me that there are more losses than benefits in that sector.

I also would point to the profit motives in the field of private medical practice, and the decisions on elective surgery. You may know that the United States, with its private fee-for-service system of surgical decisions, has a rate of elective surgery almost exactly double that of the United Kingdom; yet the life expectancy of Americans, males and females, in the age levels where most elective surgery is performed, is poorer than that in the United Kingdom.

So there seems to be a good deal of evidence that the profit motive (whether it is subconscious or conscious, is a question which one could debate) in the decisions of doctors, in the whole medical care system, seems to lead to a good deal of surgery of dubious value.

I would suggest that, in general, insofar as one goes by the past evidence, the profit motive has led to serious difficulties for the patients in the United States.

Mr. SHARP. Just one last question, Doctor. In your testimony you made the observation that these organizations, and I take it that you are talking about commercial carriers, wish to "tailor their offerings."

We have heard testimony here that one of the advantages of having a competitive environment for health insurance is that it allows a person free choice of what he needs, and yet we are told that it is the doctor who controls the cost of medical care.

Would you expand a little on that "tailoring their offerings" concept? What are you really getting at there?

Dr. ROEMER. Yes. This does seem to be a frequent defense of the practices of commercial insurance companies, and also of the Blue Cross and Blue Shield plans.

But our study seems to suggest that, as far as the consumer's wishes are concerned, he seems to be a good deal more satisfied with the protection offered by the group practice plans despite their having higher premiums.

The higher premiums are associated with more comprehensive benefits, so that if the argument of tailoring to individual wishes were valid, it would seem that all insurance carriers ought to offer the widest range of benefits, rather than the more restrictive range of benefits that they seem now to offer.

Mr. SHARP. In essence then what you are really saying is that up front the health insurance premium looks good. The premium may be lower, but the out-of-pocket costs are higher. But with the full range of health services the consumer is getting the better bargain in the marketplace with the prepaid group practice plan.

Dr. ROEMER. He is getting it and evidently he appreciates it, when asked about his satisfaction. He evidently, in a substantial majority of instances, is sufficiently aware of what is happening, but he prefers to pay the higher premium and get the greater benefits.

Mr. SHARP. Does the consumer know that part of the total price is these out-of-pocket costs, which most people do not realize until the illness or the tragedy strikes, as we have had witnesses here testify—isn't that the hidden cost in all of this?

Dr. ROEMER. I would suspect that if the consumer knew the full impact of the costs, that we learned, for example, from our study, the degree of satisfaction with the group practice plans would be even overwhelmingly higher than we found it to be.

We found, as you recall, 65 percent high satisfaction with the financial protection of the group practice plans, as compared with 36 percent in the commercial plans, and 28 percent in the provider plans.

I would suspect that if consumers knew the details of what the cumulative costs and out-of-pocket expenses came to, their satisfaction level with the group practice plans would have been even higher, and with the other types of plans even lower.

Mr. SHARP. Doctor, thank you very much.

Dr. ROEMER. Thank you, sir.

Senator HART. Mr. Chumbris?

Mr. CHUMBRIS. Thank you, Mr. Chairman.

Bearing in mind that the Federal Trade Commission in one case came to a unanimous decision that each of the Commissioners wrote a separate opinion, I would say that in view of the statement that you have made which is detailed, that there will be many people who would look at it from probably a little different angle.

I think that this is the type of thing that requires a lot of study. This is a paper that requires quite a bit of study, and I am sure that there will be various opinions that will be submitted to this subcommittee, some taking issue with you on certain points, and agreeing with you on others.

Hence, Mr. Chairman, I have no questions.

Dr. ROEMER. I would point out, Mr. Chumbris, that one question has been frequently put to us, "Why did you take so many years to report this data," and as I said, the actual field data comes from 1967-68, which is several years ago.

The answer is that we wanted to be very sure that our data was sound; that we had eliminated any sampling bias or any bias or inaccuracy in responses and in the analyses of responses.

It has taken us this long to issue a final report because we were exerting the greatest care, which therefore means that we are quite confident of the validity of our findings.

Mr. CHUMBRIS. I am not trying to say the question of bias, but when you look at statistics, you are going to find people reading the statistics in a different light.

Dr. ROEMER. Yes.

Mr. SHARP. Senator. Dr. Roemer is going to supply for the subcommittee the full study. I believe his study is going to be made public. But in my conversations with you, doctor, I understand that there is even a more comprehensive analysis which contains many, many pages

of the sampling techniques, and other factors, and the statistical justifications, and what have you.

Bearing in mind what Mr. Chumbris just raised, perhaps it would be a good idea for you to supply for the subcommittee files the statistical analyses and interpretations so that we will have those in case anyone questions the basis of this study.

Dr. ROEMER. We will be glad to do that, sir.

Mr. SHARP. Thank you very much.

Senator HART. Doctor, for all of us, thank you very much.

The schedule problems for all of us sometimes makes it difficult for us to proceed with the subcommittee hearings.

I have a matter which developed only this morning, and it requires my attention, but it should involve no more than 20 minutes.

We will recess for about 20 minutes, and then continue with the scheduled witnesses and forget lunch.

(Whereupon, a short recess was taken.)

STATEMENT OF RAYMOND A. BIERSCHBACH, OCCIDENTAL LIFE INSURANCE CO. OF CALIFORNIA

Senator HART. The committee will be in order. And we are grateful that the Senator from California, Mr. Tunney, who is engaged in the Kleindienst nominee matter on the floor, has been able to, at least for a portion of the hearing beginning now, join us.

Our next scheduled witness is the vice president of Occidental Life of California, Ray A. Bierschbach—am I pronouncing that correctly?

Mr. BIERSCHBACH. Yes, sir.

Senator HART. If there is no objection, we will order printed in the record in full, as given, the statement that has been prepared and filed with us. If you would care to summarize or to footnote or expand, in either case the record will reflect this.

(Documents follow. Testimony resumes on p. 1044.)

A PRESENTATION BY OCCIDENTAL LIFE INSURANCE COMPANY OF CALIFORNIA TO THE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY, JUNE 7, 1972

This presentation is being made in response to a letter from the Chairman of the Subcommittee on Antitrust and Monopoly, Senator Philip A. Hart, to Mr. Earl Clark, Chairman of the Board and Chief Executive Officer of Occidental Life Insurance Company of California. Senator Hart's letter was dated April 24, 1972, and this presentation will answer the questions contained in that letter.

The first question asked in Senator Hart's letter was "Whether or not commercial accident and health insurance companies are returning a sufficient amount and health insurance premium dollar in benefits to consumers."

We will first deal with the group portion of the question.

In the group health insurance field for 1971, our claim ratio was 95% of the premium. Our operating expenses were 4% of premium, our commissions were 2%, and taxes accounted for 2% of group premium. The percentages quoted add up to more than 100% of the premium. In addition to premium income we have investment income. This investment income allowed us to make a minimal profit in the group accident and health insurance line in 1971. However, the profits before Federal income taxes were less than one-tenth of one percent of the earned premiums. In our opinion, there is no doubt that a sufficient amount of the premium dollar is being returned in benefits to the consumer in the group line.

In our individual health line, claims incurred accounted for 62% of premiums earned during 1971. General insurance expenses accounted for 31% of the premium dollar, commissions amount to 19%, and taxes, licenses and fees, 3%. For

this line of business after investment income we lost \$851,000 for the year which after federal income taxes was reduced to a net loss of \$488,000.

Some further discussion of the percentages above may be helpful. First, the 19% of the premium dollar which was absorbed in commissions: The commission ratio is our weighted average for both medical care coverage and disability income coverage. We pay a lower commission on medical care coverage than on disability income sales. We pay a higher commission in the first policy year than we do in renewal years. The higher first year commission is to encourage the sale of our individual policies. It is our experience that individual health insurance is primarily sold, not bought. Without the salesmen, many of the people who have our coverage would not be covered in the event of accident or sickness and would be faced with having to provide medical care costs entirely out of their own pockets. We feel that they are better off with the coverage than without it and that the commission paid to the agent to sell the coverage is certainly justified. We feel that renewal commissions must also be paid. Without them, the agent would not be rewarded for providing service to his customer, the consumer. These services include an explanation of the policy itself, assistance in completing claim forms, addition of coverage for newborn dependents and advice as to the adequacy of coverage within the framework of the customer's ability to pay with the purpose of trying to continually update the coverage to meet the insured's needs.

The 31% of premium which went for general insurance expenses represents the average expense ratio for all policies on the books, including those just written. The cost of putting individual accident and health insurance policies on the books is substantial. The policies have to be underwritten and individual policy records set up. There is a considerable amount of detail which has to be included in the company records. Much of this information must be kept in order to meet legal requirements. Since we pay premium taxes to the states, we must be able to process our cash premiums on a state-by-state basis. The State of Louisiana even requires a breakdown by parish for tax purposes. We obviously have to record the name and address of the insured, the list of family members covered by the policy, the detail of the benefits to be provided, the method of premium payment, the effective date of the policy, the scheduled termination date of coverage of every individual covered under the policy, and many other details. These records are necessary to provide the services desired by the policyholder and the tax information required by the various states.

The ratio of claims paid to premiums earned is looked upon by many to be the measure of how much of the premium dollar is being returned to the buyer. Indeed it is but care must be taken when using this ratio to decide if an adequate portion is being returned, or in using the ratios of two different companies to measure one company against another. The interpretation of the loss ratio is complicated by the fact that individual health insurance policies are sold primarily on a premium basis, whereas the incidence of claims is expected to rise with the duration of the policies.

An illustration of this point is attached as Exhibit 1. The course of the table is the authoritative insurance textbook titled "Health Insurance Provided through Individual Policies" published by the Society of Actuaries. This table shows the development of yearly and cumulative loss ratios on a block of 1,000 illustrative medical policies issued at age 40 on a level premium to age 65 basis. While this illustration is based on major medical insurance, the pattern is typical of the expected experience on any level premium individual accident and health insurance policy where the right to renew is guaranteed to the consumer.

Turning to the illustration if all of the policies in the block were within the first year of their existence, a 26% loss ratio would be expected. If, on the other hand, all of the policies were in their eleventh year of existence (see age 50), a loss ratio of 65.5% would be expected. Note that the total of claims paid as a percentage of premium paid when the last policy goes off the books at age 65 reaches a 61% level, but in that year the loss ratio is 77.7%.

In addition to the distribution by year of issue, the claim loss ratio on any block of business will be affected by the ages of the insureds, secular trends, the average size of the policies, the nature of the policy guarantees, the mode of premium payment, and the method of establishing policy reserves.

The loss ratio pattern will also be affected by the type of risk being covered. For example, when the product is one for which inflation has an impact on the cost of benefits provided, the level premium rate must be set high enough to cover the anticipated cost of inflation. This is not the case when benefits provided are expressed as a fixed dollar amount.

Further, the loss ratio is also affected by the type of policy. For example, if an insured's cash balances are such that he can sustain a rather severe financial blow, he may want to buy a policy with fairly high deductibles and self-insure the balance. Such a policy would carry a lower premium than one covering the risk from the first dollar, a policy where the premium would be much higher. Yet the expense to the company of writing either policy might be very similar in amount. The reason for this is that general administrative expenses for record keeping, data processing, policyholders' service and the like are independent of the amount of premium on the policy. As a result, the individual buying the higher deductible policy may very well see a lesser percentage of his premium dollar returned in the form of claims, but he has paid less than the individual who covered the first dollar of medical expense, and more importantly, he has obtained the coverage he wanted.

We conclude then that in the group health insurance line where 95% of the premiums are returned to the consumer, a sufficient proportion of the premium is being returned to the consumer. Furthermore, when one recognizes the level of the necessary expenses associated with the individual health insurance line, we feel that we are returning a sufficient proportion of the premiums for that line to the consumer.

The second question in the letter of April 24 was "Whether or not accident and health insurance policies should be standardized by regulation".

Standardization can take many different forms. Perhaps a discussion of some of the more important concepts of standardization may be helpful.

We already have standardized wording of the various operating provisions in policy forms. Being a California domiciled company, we file our forms first with California and then with the other states in which we do business. There are certain standard provisions which are required by law to be included in any accident and health insurance policy filed with the State of California. These provisions, referred to as the Uniform Policy Provisions, are in effect in all states. The Uniform Policy Provisions Law gives companies the right to vary the wording of the statutory provisions, but only if the proposed language is more favorable to the insured.

All of the states also permit what are referred to as Optional Standard Provisions. These provisions are not required by law, but if a company elects to include any of these provisions in its policies, the language used in the policy provisions covering the subject matters referred to in the Optional Standard Provisions must be at least as favorable to the insured as the language of the Optional Standard Provisions.

Standardization could also refer to standardization of benefits. Some people envision a rigid set of benefits, something along the lines of the standard fire insurance policy. We submit that the two types of coverage should not be compared. The risk that is being insured against in a fire insurance policy remains fairly steady. A person either has a fire or he does not, and the loss can generally be determined and a specific monetary value placed on it. On the other hand, the health insurance business is dynamic. Over the past couple of decades, we have seen tremendous changes in the delivery system. These changes are occurring at an even more rapid pace today.

The physician today has a multiplicity of specialists and sophisticated equipment which were not available, or rarely used, a few years ago. To enumerate, a few of the changes which require frequent evaluation of insurance coverage have been the following: The Intensive Care Unit (ICU), which has been established in almost all hospitals where critically ill or injured persons may be cared for with a concentration of skilled personnel and sophisticated equipment. This equipment has allowed the physician the opportunity to monitor the various bodily functions and provide the physician with greater control. These devices permit the physician to follow blood pressure, pulse, respiration, temperature, cardiac output and the electrical condition over the heart. From the success of this type of care has developed the Coronary Care Unit (CCU), where in the initial critical hours of an acute myocardial infarction (heart attack) or abnormal cardiac rhythms the patient may be monitored and devices such as electrical defibrillators or cardiac pacemakers are available for prompt application.

Surgery in all fields from cancer to reconstruction has advanced by both new and more extensive procedures. Again, this has been made possible by the greater skill of the anesthesiologist and his knowledge of respiratory physiology and by the development of materials which allow for the replacement of arteries,

veins, and heart valves. In other situations, the use of tissues from a donor or organ bank can be utilized in the replacement of kidneys, bone grafting, the cornea of the eye, and now increasing success in transplantation of the liver.

A recent change in medicine is the emerging trend toward the use of paramedical personnel to assist the physician in his office practice and in many areas to screen or provide primary medical care in remote or understaffed locations.

In the field of diagnosis and treatment, diagnostic procedures have been developed which allow the probing and study of almost every organ of the body by the use of special X-ray techniques, radio isotopes, scanning procedures, and by the development of fibro-optic instruments which permit the illumination and visualization of many organs.

This incomplete list of the rapid changes in all fields of medicine and medical practice would appear to dictate the need for insurance coverage which can be exceptionally flexible in covering the constantly changing requirement.

Even the facilities in which services are delivered have changed rapidly and are still changing. Intensive Care Units are largely new developments in hospitals. Free standing surgical clinics have sprung up in some areas. Since the advent of Medicare, we have seen rapid growth in convalescent homes and convalescent wings of hospitals. We are also seeing a growth of interest in Health Maintenance Organizations. With such rapid change and new developments, many of which are yet unforeseen, it is difficult to envision the type of standardization of accident and health policies that we have with fire policies.

We oppose standardization by rigid fixing of benefits and feel this solution is contrary to the best interests of the public. We would, however, support a nationally established standardized minimum benefit health insurance package, if the standardization were flexible enough to allow variations in the minimums to account for economic differences between different localities. If such a minimum benefit package were established, we feel insurance companies should be free to market policies which have benefits in excess of the minimum benefits. Furthermore, we feel companies should be free to market policies whose benefits are less than those prescribed by the minimum benefit package. But, in doing so, the companies should be required to clearly indicate in their advertising and on these policy forms the fact that the policies do not meet the minimum benefit requirements. Establishing minimum benefits for accident and health insurance would need to be done with care, so as to preserve the flexibility needed to develop innovative insurance coverages which will parallel the progress in medicine. Regardless, sound and proper regulation is essential and a brief review of some of the extensive regulations applicable to accident and health policies today may be of benefit to the Committee.

Every individual accident and health policy form must be filed prior to sale with the state insurance department of every state in which the policy will be sold. All of the states have the right to disapprove any policy form which might be misleading. For example, the California Insurance Code, Section 10291.5 reads as follows: "10291.5(b). The Commissioner shall not approve any disability policy for issuance in this state: (1) if he finds that it contains any provision, or has any label, description of its contents, title, heading, backing, or other indication of its provisions which is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued". The term "disability policy" as used in the California Insurance Code includes, by definition, any individual policy providing any form of medical care benefits.

In addition, along with most of the companies in the industry we comply with the NAIC rules governing the advertising of accident and health insurance. The model regulation spells out quite specifically what can and cannot be said, as well as what must be said in any advertising or sales material used in connection with accident and health insurance. These regulations are constantly being updated by the state insurance departments and our own California Insurance Commissioner has just conducted public hearings and the issuance of new regulations to cover evolving problems.

Examples of the types of material regulated are the following :

"DECEPTIVE WORDS, PHRASES, OR ILLUSTRATIONS"

Words, phrases or illustrations should not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered, or premium payable. An advertisement relating

to any policy benefit payable, loss covered, or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive."

"EXCEPTIONS, REDUCTIONS, AND LIMITATIONS"

When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit, or the loss of which such benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive."

The buyer of individual health insurance policies has still another protection. If a policyholder does not understand his coverage or does not feel that he has bought what he thought he was buying, he can ask for an explanation or return the policy. All of our policies contain a 10-day free-look provision which reads, "If for any reason you are not satisfied with your policy, you may return it to Occidental within 10 days of the date you received it and the premium you paid will be promptly refunded."

One of the prime arguments for standardization in any insurance is the admitted complexity of some of the insurance policies because of their multitude benefits. In group insurance, which represents over 90% of Occidental's accident and health business, there is a mitigating factor. Frequently, a group health insurance program will be negotiated by a highly sophisticated team from a labor union, with both the union and the employer exerting every effort to make sure the employees fully understand and appreciate the benefits which have been negotiated, or by an employer seeking these same aims plus the building of a benefit package which will enable him to attract and retain good employees.

We feel the most adverse effects of rigid standardization could be the stifling of competition among insurers. The element of competition under our economic system is, in our opinion, one of the most effective regulators of the business. Competition, plus the ability to experiment, has stimulated the rapid growth and expansion of the health insurance business. Competition cannot exist without the right to experiment with new coverages. If policies had been standardized 20 years ago, we might not have seen the development of noncancellable and guaranteed renewable hospital, medical and surgical policies; guaranteed renewable lifetime medical care coverages; comprehensive and major medical policies; guaranteed renewable disability income policies; noncancellable disability policies with return of premium provisions, and many other new coverages such as dental insurance, nursing home, and home health care benefits.

In summary then, we feel that the existing standardization of accident and health insurance policies could be supplemented by the introduction of a flexible standardized minimum benefit package. We feel that other policies should be available to the public, and that all efforts toward standardization must be carefully undertaken to allow flexibility so policies may keep abreast of the changes in medical care. Furthermore, we support the state regulatory system to control nonstandardized policies.

The third question of the April 24, 1972, letter asks whether or not accident and health insurance rates should be regulated.

This presentation will first discuss rate regulation with regard to group health insurance. As said before, we returned 95 cents out of every dollar collected in 1971 in benefits to consumers. With this percentage being returned to the consumers, we do not feel that there are any advantages to be gained by further rate regulation in the group health insurance field. There is vigorous competition among private insurers, Blue Cross and self-financing in the group field. Employers and unions carefully shop for the best possible price for a particular set of benefits. For all of our groups, the premium rates charged are based on the experience of each individual group. For large groups, any excess of premiums charged over claims and the insurance company's retention is returned in the form of experience-rating refunds. We conclude that rate regulation of group health insurance is unnecessary; competition does a thorough job in this area.

Competition in the industry also works as a very effective rate regulator of individual accident and health insurance. When setting the premium for a policy, the actuary can make two mistakes: he can set the premium too high, or set it too low. If he sets it too high, the policies are not going to sell. If he makes the other error and sets the premium too low, sales may be fantastic, but an analysis of the experience will show that the premiums are not sufficient to carry the benefits provided. Good business judgment then dictates that the actuary

must steer a very tight course between premiums that are too high (and inhibit the sale of business) and premiums that are too low (and inadequate).

The insurance commissioners will influence his decisions in two ways. Commissioners are concerned about premiums that are too low because they could lead to insolvency. Many commissioners also have the right to refuse to permit premium increases which in their judgment are not justified.

We cannot envision a form of governmental rate regulation that would be as effective as competition.

Before leaving this subject, it should be noted that several times since the 1940's the National Association of Insurance Commissioners has considered the question of whether or not health insurance rates should be regulated. They have concluded that it was not in the public's interest to include health insurance rates within the legislation governing rates for fire, marine, casualty, and surety coverage. In reaching that decision, it was recognized that accident and health insurance premium rates are established by the experience of each insurer, and that keen competition exists. Unlike the fire and casualty business, there is no industry action to establish accident and health premium rates which would require regulation by public authority.

The effect of rate regulation would also tend to stifle the development of new and experimental coverages. If there is a lack of sufficient data on which to base rates, companies would be hesitant to offer new coverages, knowing that the rates would be regulated and that they might not have an opportunity to adjust them if they proved to be inadequate.

We do not think that it is safe to assume that rate regulation would be the panacea for keeping down the costs of medical insurance plans. Certainly, the rates for Part B of Medicare are regulated. Furthermore, the coverage is standardized. However, the rates for Part B of Medicare have increased four times since Medicare became effective in 1966. They are now 93% higher than they were when Medicare began. We believe this indicates that standardization of forms and rate regulation are not the final solutions to the problems we face.

This presentation will next deal with the questions in the April 24, 1972, letter which deal with the Medical Information Bureau (M.I.B.). Before handling the individual items included in the letter, we would first like to establish two facts:

1. M.I.B. information is reported in code and there are strict rules applicable to the using companies to preserve the confidential nature of such information.
2. The information received through M.I.B. is not a substitute for formal underwriting evaluation. It can be used only as an alert signal that more information may be needed and can never be used wholly or in part as a reason for declining, rating, or giving a final adverse decision.

The April 24, 1972, letter lists several items and asks whether or not each is a source of medical data furnished by Occidental Life to M.I.B. These items are listed below along with our answers for each:

Question (a). Insurance company medical examinations for life insurance applicants.

Answer. Yes.

Question (b). Insurance company medical examinations for health and accident insurance applicants.

Answer. Yes.

Question (c). Medical records of attending physicians.

Answer. Yes.

Question (d). Medical records of hospitals.

Answer. Yes.

Question (e). U.S. Veterans Administration medical records.

Answer. We do use these records as a source, but when we report a code to M.I.B. it is interpreted as "Medical information obtained from a Federal agency" and no details will be given.

Question (f). U.S. Department of Defense medical records.

Answer. Same answer as to (e).

Question (g). Other Federal, state, county and municipal medical record sources (please specify each).

Answer. For Federal records, the answer would be the same as to (e). For state, county, and municipal medical record sources, we use these unless the information is indicated as confidential in which event we would handle as for Federal sources.

Question (h). Independent laboratory records.

Answer. Yes, but we seldom receive such information and then only through medical reports from doctors or hospitals.

Question (i). *Pharmacy records.*

Answer. Same as to (h).

Question (j). *Information from other insurance companies.*

Answer. The only time we would use information from other insurance companies as a source for an M.I.B. report is when we get reinsurance from a company which is not a member of M.I.B.

Question (k). *Records of manufacturers of medical appliances and devices.*

Answer. No.

Question (l). *Records of executive examination agencies.*

Answer. No, unless such information comes to us through the doctor of the proposed insured with the authorization of the proposed insured.

Question (m). *Records of voluntary health agencies.*

Answer. We do not know what is meant by "voluntary health agencies".

Question (n). *Blood bank records.*

Answer. No.

Question (o). *Voluntary alcoholic assistance agencies' records.*

Answer. If this means Alcoholics Anonymous, we do not seek information from Alcoholics Anonymous.

Question (p). *Voluntary drug assistance agencies' records.*

Answer. If this means something like a community center manned by volunteers to help people with drug problems, we do not receive information from such centers.

Question (q). *Other sources. Please specify each.*

Answer. The only other source for medical data would be from the proposed insured.

In regard to the questions about charges for service provided by the M.I.B., most of such charges are included in item 4.3 of Exhibit 5 of our Annual Statement. The M.I.B. automation charge for life insurance for 1970 was \$3,654.31, and for 1971 was \$4,477.18. For accident and health, 1970 was \$993.20 and 1971 was \$1,216.86.

The M.I.B. utilization cost for life insurance for 1970 and 1971 was:

	1970	1971
Basic charge:		
Life.....	\$7, 249. 63	\$8, 954. 22
Accident and health.....	1, 970. 39	2, 433. 69
Total.....	9, 220. 02	11, 387. 97
Checking service:		
Life.....	54, 106. 88	50, 214. 03
Accident and health.....	14, 207. 97	11, 837. 21
Total.....	68, 314. 85	62, 051. 24
Other services:		
Life.....	17, 362. 62	6, 678. 03
Accident and health.....	1, 745. 58	3, 743. 61
Total.....	19, 108. 20	10, 421. 64
Total utilization cost.....	96, 643. 07	83, 860. 85

There is a separate charge for the cost of the "Executive" Committee of M. I. B. This is found in Schedule G and is also found in Exhibit 5, line 6.2. The total charge for 1970 was \$1,100.00 and it was the same for 1971. On Exhibit 5 this is allocated as follows: Life \$833.31, Accident-Health \$251.29, and Investment \$15.40.

Your fourth question asks, "What, if any, overall structural and fiscal changes are necessary to effectuate a system of comprehensive health care and insurance, including preventive and out-patient health care services, for all consumers regardless of their financial means?"

After considering all aspects of the question you ask, we feel the health care problems of our country fall into two basic categories:

(a) Shortages and poor distribution of manpower and facilities including the need to make ambulatory care available to everyone; and

(b) Need for both access to and financing of quality health care for the poor and near poor.

Analyzing what is possible in relation to all that is desirable, we feel a program incorporating the following principles will best accomplish the task set forth by your question.

1. Heavy participation by the private sector.

One of the basic problems is that of financing the cost of health care. It is generally agreed that an insurance mechanism will be utilized (as contrasted by a socialized medicine system as found in Great Britain). Thus, the question becomes—who will fund and operate it? (There are also interrelated questions of inflation control, ability to pay, etc., that will be discussed elsewhere.)

We believe that the record shows a good effort to date by the private sector in this area; a record that justifies continued confidence in this sector given a proper mandate.

The statistics showing the remarkable growth in insurance coverages are already a part of the record of this Committee and we will not burden the record with repeating those figures here. They clearly demonstrate that this mechanism has played an important role and is constantly seeking new ways in which to play a greater and more effective role. A great body of expertise has developed within this industry that enables it to do as effective a job as it does. There are coverage shortcomings (particularly relating to the poor and near poor) but we believe these can be taken care of by a combination of Government direction and incentive with a great effort on the part of the involved companies as noted later. We believe that the past performance of this industry justifies the conclusion that it can effectively respond in the future. We are of the opinion that the best course in the circumstance where a system has performed well, but needs improvement, is not to discard the system, but rather to build upon its strengths and to correct its weaknesses. There is no justification for discarding the accumulated experience of thousands of persons in exchange for a new Federal bureau. Destruction of a tested system which has shown capabilities of change and adaptation is wasteful, especially when contrasted with the inevitable costly mistakes that will be made by any new system. Retention of the private system preserves an element of healthy competition which will strive to produce better service at lower cost; such motivation can only be attained in a pluralistic system. The possibility of success for such a privately administered program is indeed supported by the success of the present private group insurance system and the privately administered Federal Medicare program.

The government should set certain minimum standards for insurance protection and then through a mandate or incentive program ensure that all Americans are covered (whether employed or self-employed). At the same time, the government should be sure that such protection applies to any delivery system selected, be it HMO or fee-for-service physician.

We cannot overlook the present and possible future burdens of social security tax increases on the many thousands of small businesses in our country. These taxes have already become so heavy they are a source of concern. Any program adopted must consider the economic and social impact of stifling the wholesome competition of small businessmen.

If there is to be this partnership between government and business, some consideration must be given to the regulation of the industry that will operate the partnership.

2. State regulation of the insurance industry

We believe that the track record of state regulatory bodies which oversee the health insurance industry has been quite good. As in any regulatory system, there are exceptions. However, most of the state insurance departments have, like the industry that they regulate, developed considerable expertise in their business. As noted in the discussion above, it would be wasteful and unjustifiable to discard such expertise in an area as vital as this. Consequently, we believe that regulation of the health industry should be preserved at the state level.

However, the industry also recognizes that the problem of health care is a national one and that certain national standards must be met. We recognize that if the national government is to mandate or provide incentives for certain minimum coverages, that it must be able to guarantee that such coverages will be provided. We realize that certain other national controls may be desirable. Consequently, we believe that it is desirable that national standards be set and periodically reviewed by a national commission of one description or another. But, we emphasize the importance of leaving enforcement to state regulatory bodies who are much more effectively equipped to perform that enforcement than would be any newly created Federal government bureau. To the extent that individual states are unwilling or unable to perform this task, then and only then should the Federal Government undertake this regulation.

3. Provisions for inflation

The primary inflation cause is supply and demand. Consequently, a further expansion of financing demand without any increase in the services supply will increase this problem. Thus, any legislative program that attempts to confront the problems of national health care must, of necessity, provide for increased support to medical education and research; must provide for increased use of medical assistants so that existing services can serve a larger number of people than is currently possible; must encourage greater use of ambulatory care facilities prepaid group practices, and so on. Community health care planning must be improved to better distribute current and future health resources.

We recognize that there will be a lag in time between the increased support of medical education and subsequent increase of physician output. There will be similar lags in other programs to increase supply in an effort to reduce and control cost. Therefore, we suggest that whatever changes are made in the financing system, be phased in on a schedule which is coordinated with the growth in the supply of services. This will minimize inflationary pressures. At the same time, we believe that wherever possible persons must have some involvement in the cost of their medical care. Such involvement, through the use of coinsurance and deductibles, can go a long way toward discouraging overutilization. At the same time, we realize that such cost consciousness factors must not impede the progress of the poor toward improved health. Other cost reducing incentives are available and should be simultaneously implemented, such as peer review, prospective service payments, equality of payment for equal service rendered, etc.

4. Provisions for the poor and the uninsurable

Since we believe that every American should have equal access to quality medical care, special provision must be made for those who, through no fault of their own, are unable to fully participate in the financing of their own protection. Such persons, regardless of how they are designated, or by what criteria, should have a dignified opportunity to receive good health care. We believe that such provision can be made using the private sector as a primary carrier or as an administrator. There is an obvious analogy to the current Medicare program and we are proud of the fine record we have made as one of the administrators of that program.

As a primary carrier, private insurers who are participating in the minimum standards program could form state insurance pools for all those not covered in the employer-employee program. Risk of loss could be apportioned between government and carriers. On the other hand, Medicaid could be further extended and administered through the private sector much as Medicare is administered currently. Either approach would utilize the administrative expertise of the private sector with its attendant advantages of cost consciousness, competition, etc., and thus, would be able to supply better coverage at lower cost than a Federal bureau.

EXHIBIT I

ILLUSTRATIVE MAJOR MEDICAL POLICY—EMERGENCE OF LOSS RATIOS (ISSUE AGE 40—25 YEAR PROJECTION)

Age reg. of year	Policies start of year	Premiums received ((1) times \$163.49)	Increase in reserve	Earned premiums ((2) minus (3))	Select annual claim cost per life	Incurred claims	Loss ratio (percent)	
							Yearly ((6) divided by (4))	Cumulative e (6) divided by e (4)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
40.....	1,000	\$163,490	\$43,563	\$119,927	\$30.98	\$30,949	25.8	25.8
41.....	699	114,280	16,518	97,762	38.70	27,013	27.6	26.6
42.....	592	96,786	15,132	81,654	47.07	27,818	34.1	28.7
43.....	543	88,775	15,258	73,517	56.16	30,439	41.4	31.2
44.....	503	82,235	12,364	69,871	66.02	33,142	47.4	33.7
45.....	471	77,004	10,089	66,915	76.73	36,063	53.9	36.4
46.....	445	72,753	8,657	64,096	80.36	35,680	55.7	38.5
47.....	424	69,320	7,367	61,953	84.26	35,642	57.5	40.4
48.....	408	66,704	6,569	60,135	88.43	35,991	59.9	42.1
49.....	397	64,906	6,228	58,678	92.85	36,769	62.7	43.7
50.....	390	63,761	5,841	57,920	97.58	37,959	65.5	45.2
51.....	387	63,271	5,208	58,063	102.68	39,532	68.1	46.8
52.....	383	62,617	3,354	59,263	108.19	41,220	69.6	48.2
53.....	379	61,963	1,363	60,600	114.08	43,008	71.0	49.6
54.....	375	61,309	-749	62,058	120.30	44,872	72.3	50.9
55.....	371	60,655	-3,401	64,056	126.83	46,800	73.1	52.2
56.....	366	59,837	-5,741	65,578	133.69	48,663	74.2	53.4
57.....	361	59,020	-8,591	67,611	140.89	50,439	74.6	54.6
58.....	355	58,039	-11,127	69,166	148.43	52,247	75.5	55.7
59.....	349	57,058	-13,776	70,834	156.30	54,080	76.3	56.7
60.....	343	56,077	-16,844	72,921	164.55	55,947	76.7	57.7
61.....	336	54,933	-19,691	74,624	173.21	57,679	77.3	58.7
62.....	329	53,788	-22,841	76,629	182.25	59,231	77.3	59.6
63.....	321	52,480	-25,909	78,389	191.63	60,747	77.5	60.4
64.....	312	51,009	-28,841	79,850	201.38	62,025	77.7	61.2
Total.....		1,772,070	0	1,772,070		1,083,955		

Senator TUNNEY. Mr. Chairman, I am sorry that I have not been able to attend this morning's hearings because I know how valuable they have been to the subcommittee.

As you indicated, I have been very much tied up in the Kleindienst confirmation.

I understand that Dr. Roemer was here—a constituent of mine—and gave a very fine statement, and I certainly want to say that I am sure that it is going to be typical of the statements of my constituents.

I understand that Mr. Bierschbach and Mr. Frost have been cooperating extensively with the subcommittee and have volunteered to give a great deal of material to the staff and I am most appreciative of that. I know that the subcommittee staff is too, and I understand that your company is one of many that is being studied with regard to competition in the health insurance business.

I want to congratulate your company for cooperating so fully and I hope that you continue to do so.

Mr. BIRSCHBACH. Thank you, Senator.

STATEMENT OF RAYMOND A. BIRSCHBACH, EXECUTIVE VICE PRESIDENT AND ACTUARY OF OCCIDENTAL LIFE INSURANCE CO. OF CALIFORNIA

My name is Raymond A. Bierschbach. I am executive vice president and actuary of Occidental Life Insurance Co. of California.

With me today is O. L. Frost, Jr., who is vice president and assistant to the chairman of the board of our company.

We are pleased to respond to this committee's request for our views on the role of the commercial accident and health insurance industry and its effect on providing health care services and resources to the American people. Our company has cooperated with the Federal Government in this area in the past and will continue to work with the Congress to bring about an even higher standard of health care for all of our citizens.

My oral comments will summarize our longer, formal statement which has already been supplied to the committee and, Mr. Chairman, I thank you for making this a part of the record as I thank you for your consideration of our timing problem.

Earlier in these hearings, negative comments regarding our company were made concerning a routine audit report issued by HEW last September involving our administration of part B of medicare for southern California.

Because this matter was raised in these proceedings, we would like to state for the record that the HEW auditors did not, at any time, accuse Occidental of any malfeasance.

Furthermore, HEW's detailed investigations subsequent to the audit fully verified Occidental's fine record as an administrator. Documentation to that effect is contained in a summary report of the meeting between the Bureau of Health Insurance regional office of the Social Security Administration and Occidental Life Insurance Co. of California, dated May 5, 1972. Mr. Chairman, I would like to request that a copy of this report be made a part of the record.

Senator HART. It will be entered at this time.

(Document follows. Testimony resumes on p. 1049.)

MEETING BETWEEN THE BUREAU OF HEALTH INSURANCE REGIONAL OFFICE, SSA, SAN FRANCISCO, AND OCCIDENTAL LIFE INSURANCE COMPANY AT LOS ANGELES, CALIF., MAY 5, 1972

BHI REPRESENTATIVES

Mrs. Mercia Leton Kahn, Regional Representative
Mr. John O'Hara, Jr., Program Officer—Contractors
Mr. Tom Burtscher, Resident BHI Representative
Mr. Jack McGinity, Reimbursement Specialist

OCCIDENTAL REPRESENTATIVES

Mr. A. B. Halverson, Senior Executive Vice President
Mr. Karl Anderson, Executive Vice President
Mr. John T. Fulton, Second Vice President and Chief, Medicare Administrator
Mr. A. R. Colles, Chief, Accounting Officer
Mr. George W. Crum, Medicare Cost Accountant

The purpose of the meeting was to discuss and if possible close out the HEW Audit, ACN 20001-09 dated 9/15/71 covering the period (1) Administrative Costs for 1/1/68-12/31/69 and, (2) Benefit Payments for 10/1/68-9/30/68.

The Bureau of Health Insurance Regional Office had conducted a series of follow-up reviews at Occidental covering the HEW Audit. Based on these reviews, it was determined that Occidental had acted on all recommendations with reasonable assurance that disbursements made by Occidental are in accordance with good administrative practices. There appears to be no area of significant disagreement either in the Management area or the Administrative Cost area.

Following is a summary of the meeting.

I. Claims Control of Exceptional Providers

A. Findings.

HEW Audit stated: "OLIC made payments to physicians and medical groups which had past histories of irregular or unusual billing practices without adequately reviewing the propriety of the services or amounts claimed. As a result, there was no assurance that the \$3.2 million paid to these providers during 1970 was allowable."

The Audit based their comments on a review of 248 sample claims which were reviewed from the standpoint of documentation. HEW Audit did not go into the medical necessity of the services. Occidental rereviewed 219 of the 248 claims and ascertained that only \$96.40 had been improperly paid. There was no indication of \$3.2 million being incorrectly paid.

Of the 365 physicians on Occidental's "Exceptional Supplier List" only 2 had their payments suspended by BHI due to the possibility of fraud; a third was under investigation. The rest were on the list due to a tax levy, overpayment to be collected back or as possible overutilizers.

B. HEW Audit Recommendations and BHI Follow-Up Review Findings.

1. HEW Audit recommended that bypass codes and the ESL lists be restricted to senior claims personnel and that payment should not be made until proper authorization is granted.

The BHI follow-up review verified that only senior claims examiners or management personnel now have the ESL lists and that all claims concerning a physician on the ESL go to these people for review and authorization of payment.

2. Letters of certification should be obtained from all clinics and payments should be suspended to those who have not submitted letters.

Occidental has obtained certifications for all clinics and as of May 5, 1972, is updating their certifications.

3. Clinics having members on the ESL should be added to the list.

Occidental has now identified over 5,000 physicians belonging to one or more clinics and can now list the group or clinic on the ESL as well as any of the other member doctors.

4. All claim folders should accompany the new claim when it is reviewed by the Medical Consultants, and all claims needing medical evaluation should be so reviewed.

The percentage of claims going to the Medical Consultants has risen from 4% to 9%. Approximately 37% of the claims have the file folder attached, and it is extremely easy for the medical consultant to obtain the claims folder when desired. BHI agreed with Occidental that current procedures are appropriate since a check with the consultants indicated that the folder was not needed in many cases and was readily available if necessary.

5. Standard criteria should be established for the identification of exceptional providers.

Occidental has now developed basic guidelines.

C. Conclusions.

BHI concurs that there was no evidence that \$3.2 million was improperly paid. Necessary and proper steps have been taken by Occidental to implement the recommendations made on the above items.

II. Controls Over EFC and Nursing Home Visits

A. Findings.

HEW Audit stated: "OLIC processed claims for physicians' visits to extended care facilities and nursing homes as visits to acute hospitals because providers had not been required to identify the facility visited. As a result, during the 24-month period OLIC had paid claims for excessive visits which exceeded allowable charges by about \$437,000."

HEW Audit reviewed 491 visits in the 2-year period and stated 22% were overpayments because the visits exceeded Occidental's guidelines, which are 3 visits per month to patients in ECF's. The audit concentrated on documentation of the claims file and did not go into the actual medical necessity of the visits.

B. HEW Audit Recommendations and BHI Follow-Up Review Findings.

All providers should be required to identify on all claims the type of facility visited.

Although most claims (87%) had the name of the facility, they usually had in addition either an RVS code or a written description identifying the place of service. In 13% of the cases where the name was omitted, other information identified the type of the facility. Since in California few ECF's are hospital-based, the name, if known or checked in the directory, is a good indication of the type of facility. However, to assure accuracy, Occidental will require at least two assurances of the type of facility such as the written description, RVS code or name.

The Audit reports comment that excessive visits exceeded allowable charges by \$437,000 results from a strict interpretation of Occidental manual, which states that three visits per month to patients in ECF's and nursing homes are permitted. However, this is only a guide and claims examiners are permitted to exercise judgment and allow more than these visits where medically justified.

C. Conclusion.

The claims are now showing the place of the service and generally the name. Occidental will issue a bulletin reminding the physicians to always show the name of the facility and the place of service and is emphasizing thorough review. It is felt that all necessary and proper steps have been taken by Occidental and there was no evidence of substantial overpayments per the explanation above.

III. Control of Durable Medical Equipment

A. Findings.

HEW Audit states: "OLIC's management of claims for durable medical equipment was not always effective in that it did not *assure* that all DME was medically necessary and that beneficiaries were not advised of their option to purchase DME when it was more economical to do so. Our review disclosed that total rental costs exceeded the purchase price of the equipment in 23% of the claims."

Under the law, Occidental has not right to require the purchase of DME. Only the beneficiary can make that decision. SSA District Offices have literature on DME, pamphlet SSI-71, which they give out and this is covered in the SSA Medicare Handbook given every beneficiary.

B. HEW Audit Recommendations and BHI Follow-Up Review Findings.

1. Occidental should obtain the physician's prescription. The BHI follow-up review verified that Occidental has instructions requiring a physician's prescription before paying the initial DME claim and that they are obtaining prescriptions. However, the physician's prescription alone cannot be used as the sole basis for medical necessity, some are for the beneficiary's convenience, but it is one factor in determining allowance.

2. Occidental should advise the beneficiary of the option to purchase DME upon submission of the initial bill.

Occidental is now sending out a purchase option letter with the initial payment and, in addition, on the 6th rental payment is adding a "purchase option reminder" on their EOMB's to the beneficiary.

3. Occidental should review all claims involving DME every 6 months obtaining a new prescription where the rental will continue.

Occidental is now doing this.

C. Conclusions.

It was agreed that the required procedures are being properly followed but that SSA in its informational and educational program has a role in informing beneficiaries. The substantial amount of the \$2.7 million distributed for DME where the rental paid by Medicare exceeded the purchase price could not be controlled by Occidental since the beneficiary had the option of deciding whether to rent or purchase, as provided by the Medicare law.

IV. Beneficiary Payments

A. Findings.

HEW Audit states: "Procedures employed by OLIC for the correction of identifiable medical payment errors were not effective, periodic follow-up reviews by the Medicare Benefits Review Department would assist in alleviating this condition."

B. HEW Audit Recommendations and BHI Follow-Up Review Findings.

Occidental's MBR Unit should perform periodic follow-up reviews of its reports to insure that all payment errors have been corrected.

Occidental now prepares a quarterly overpayment listing which is used by the MBR Unit to follow-up to see that corrective action is being taken. In addition they maintain a tickler file and spot check.

C. Conclusion.

It was agreed that proper steps have been taken.

V. Hospital-Based Physicians

A. Findings.

HEW Audit states: "OLIC was making payments to certain providers for physicians' services performed without adequate support for the reasonableness of the charge. As a result, over \$340,000 was paid to hospital-based physicians during the 12 months ending 9/30/70 without assurance that the payments were reasonable.

The \$340,000 was supported by statements from the hospitals regarding professional component but were not necessarily current or complete.

B. HEW Audit Recommendations and BHI Follow-Up Review Findings.

1. Occidental should attempt to obtain support for payments for services provided by hospital-based physicians.

Occidental has secured rationale for payments to all hospitals but two. Occidental has not made payments to these two and will not until they secure rationale.

2. Occidental should compare prior payments with documentation and make retroactive adjustments when necessary.

This is an extremely complicated area compounded by the fact that Part A Intermediary is responsible for obtaining and communicating to the Part B Carrier detailed information. It is also a continually changing situation to the extent that BHI requires quarterly updating of the rationale. Thus, current rationale would not necessarily correctly reflect the actual conditions of a prior period. In the BHI follow-up review payments under the old rationale were compared to payments that would have been made under the new, more complete rationale for a sample of services. In 24 of 95 services Occidental actually made an underpayment, the new, more complete rationale allowing a higher payment. In 16 services Occidental made an overpayment and in 55 services Occidental made approximately the same payment.

C. Conclusions.

It was agreed that it was not feasible to obtain complete rationale for the prior periods in question and apply the results retroactively, since this could not be cost justified.

VI. Letter of Credit Withdrawal Procedures

A. Findings.

HEW Audit states: "OLIC had maintained an average daily cash balance of 2.8 million dollars because it withdrew funds under its letter of credit as Medicare checks were issued. If the funds had been withdrawn as the checks were presented for payment, interest savings of about \$168,000 annually could have been realized.

HEW Audit had not taken into account the expenses incurred by the bank in handling the Medicare account that had not been charged Medicare but would be under audit's recommended procedure and would offset the savings. For example, a review of the bank's cost analysis statement for January 1972 showed their costs to handle the Medicare account to be \$13,077.52. This times 12 equals \$156,924.00 approximate yearly charges which would be subtracted from the \$168,000.00 interest savings.

B. HEW Recommendations and BHI Follow-Up Review Findings.

1. Withdrawal of funds on the letter-of-credit should be deferred until the checks are presented for payment.

Occidental has taken steps to lower the amount of the float at the bank and they are exploring the "overdraft" procedure whereby the bank would be paid after the checks are cashed and the charges the bank would make for this procedure. SSA will be providing clarifying instructions in this area.

C. Conclusion.

The \$2.8 million average bank balance maintained in the Social Security account for Medicare claims did not result in a loss of \$168,000.00 in interest or

reflect improper money management by OLIC. Occidental was following SSA's specific instructions in handling its letters of credit instructions.

VII. Administrative Costs

A. HEW Audit Recommendations and BHI Follow-Up Review Findings.

1. After the close of HEW Audit's field work, Occidental revised its calculations of allocated administration costs, resulting in a reduction of \$3,801.00 in 1968 and an increase of \$3,832.00 in 1969. Both OLIC and HEW Audit agreed to this net increase of \$31.00.

2. HEW Audit questioned Occidental's claimed public relations costs of \$6,586.00 in 1968 and \$6,596.00 in 1969. In the BHI review, additional information was obtained which substantiated Mr. Dick Trueblood's involvement in Medicare activities. The amounts in question represent approximately 13 percent of his salary and office expenses. Since Medicare did benefit, it was agreed this was an allowable expense.

3. HEW Audit questioned \$6,741.00 in Planning Department Costs. Based on a review by BHI, it was determined this was a proper cost.

4. HEW Audit felt \$1,490.00 was a re-organizational cost and not allowable. Based on the BHI review, it was determined this was an allowable cost.

5. HEW Audit questioned \$7,229.00 of claimed telephone expenses. Based on a BHI review, it was determined that the correct amount to be questioned was \$6,697.00.

6. The audit report concluded that "Classified Distribution" salaries should be considered as direct salaries in computing the percentage of indirect expenses to be allocated to Medicare. As a result, the auditors questioned \$12,683.00 in 1968 and \$17,793.00 in 1969. BHI has reviewed OLIC's allocation procedures, and concludes that a portion of "Classified Distribution" salaries should be considered direct salaries. At the time of the meeting, the amounts to be questioned had not yet been computed, but it was estimated that they would total about \$2,000.00 in 1968 and \$2,000.00 in 1969. (On May 10, 1971, it was determined that these amounts would be \$2,148.00 and \$8,370.00, respectively.) Both BHI and OLIC concur that the matter of overhead allocation is judgmental to a degree, and that the positions taken by both HEW Audit and OLIC have merit.

B. Conclusion.

BHI and Occidental both agreed to the amounts as discussed above.

Mr. BIERSCHEBACH. And so that members of this committee can better appreciate the magnitude of our responsibility to southern Californias nearly 1-million elderly residents, permit me to give you these facts:

Occidentals medicare staff paid out \$105 million in Federal benefits during the 1970-71 fiscal year, and has already paid \$110 million in benefits through May of the current fiscal year. In June 1967, at the end of its first full year of Medicare administration, Occidental was processing 4,500 claims daily. Today, that figure has increased to nearly 10,000 daily.

The balance of my oral comments today will be limited to Occidentals position on the various questions that you have raised. I do not think, though, that Occidental is dissimilar to the bulk of the other companies in the industry.

Mr. Chairman, in your letter of April 24, 1972, you asked for our views on four items. We hope our response will help your committee in its study.

Briefly summarized, we stated in our formal presentation, first, we are returning a sufficient amount of the premium dollars as benefits to the consumer. Last year, in our group health insurance line, we returned 95 percent of the premium dollars to the consumer. Group insurance represents more than 90 percent of our total health insurance coverage.

Even with the extra costs of handling individual insurance on a person-by-person basis, we returned 62 percent of the premium dollars to the owners of our individual insurance policies.

Second. An appropriate minimum benefit type of regulation could be of real value to the consumer and we support legislation and regulation toward that end. But we oppose rigid benefit standardization that would inhibit competition and thereby the redesigning of benefits to fit advances in medical science and in health care delivery systems.

Third. Competition has been demonstrated to be the most effective control of rates in both group and individual insurance. Therefore, formal rate regulation is not needed and would be against the best interests of the consumer. Rate regulation would stifle new and experimental insurance coverages without controlling health care costs.

Finally, we recognize that Americans need and are demanding better health care services and we believe a closer working relationship between Government and private enterprise is the key to the success of such improvements.

We believe that the past performance of the insurance industry justifies the conclusion that it can effectively respond to the future health care needs of our citizens. We are of the opinion that the best course in the circumstances where a system has performed well, but needs improvement, is not to discard the system, but rather to build upon its strength and correct its weaknesses.

Occidental was a leader in health care for the elderly in California before Medicare. Occidental has worked effectively in partnership with the Federal Government on Medicare. We are confident that we can continue to make a meaningful contribution to the efforts to improve health care services in the future.

We welcome the opportunity to work with the appropriate committees of Congress toward these goals and appreciate the opportunity to appear before this committee. I want to thank you for your courtesy and attention.

Mr. Frost and I will be pleased to respond to any questions you may have for us at this time.

Mr. CHUMBRIS. Mr. Chairman, as I understand it, the entire statement as it was presented earlier, will be made a part of the record.

Senator HART. It has been so entered. While the staff is reviewing the questions—some of which I am sure they want to put to you—let me raise with you just one, and perhaps it is a very narrow aspect.

I am certain you have heard of it before—it is not unique. With the insurers, who testified yesterday we were curious to find out just what was meant by a red star district.

The insurance company provided us with their underwriting guidebook and reference there was made to the desire either not to insure at all or to be cautious and selective in insuring anyone who resided in what they called a "red star district."

What we are to understand you mean in your Health Insurance Underwriting Supplement, at page 310. It speaks about, "under our new approach, you view the occupation as a red flag, but base your decision as to the need for inspection report on further details."

This is a supplement that reviews the earlier practice of requiring inspection reports for anyone in a particular occupation or activity. Do you have that?

Mr. BIERSEHBACH. I don't have that particular reference before me, sir.

Senator HART. Does it ring a bell at all?

Mr. BIERSEHBACH. The red star. We do not have any reference to a red star area in our manual that I know of.

Senator HART. No, you do not have a red star reference. Yours is a "red flag" reference.

Mr. BIERSEHBACH. Could I see that particular thing? All right, I think the complete reference, sir, is pretty clear. It indicates that in some occupations we might want to get an inspection report where you might otherwise not have a need to do so.

It goes on to say that you have to consider all the particular circumstances and, in fact, the example given in here is a waitress serving liquor. It goes on to say that if she were working in a tavern or nightclub, we might want to get an inspection report to gather more information; whereas, if she were working in a first-class restaurant or hotel, we probably would not.

Senator HART. Well, what would an inspection report—assuming one was called for—give?

Mr. BIERSEHBACH. Well, we would have to find out whether or not the applicant had the financial means to purchase the policy and continue the policy in force.

Senator HART. Well, let us suppose she were a very affluent waitress. Does that take care of your problem?

Mr. BIERSEHBACH. If she were a very affluent waitress, that probably would take care of our problem.

Senator HART. The inspection report, then, is simply a financial—

Mr. BIERSEHBACH. It is partly, yes, sir.

Senator HART. And partly what else?

Mr. BIERSEHBACH. If there had been a history of medical problems that had not been brought out in the application, that might come up in the inspection report.

Senator HART. So it is a financial and health report. Is it anything else?

Mr. BIERSEHBACH. I think that would be pretty much what it is, sir.

Senator HART. I would have gotten the impression that it was more because on page 310—A you discuss some things to look for in deciding whether or not an inspection report should be ordered.

One is a question of income. Is income high enough. It includes, also, is applicant married with children and responsibilities or single without responsibilities. Is place of employment first class or low class. Really, that goes beyond your health or financial.

Mr. BIERSEHBACH. All right. As to the point of whether or not the individual is single or married with responsibilities, this would be of primary concern in life insurance. There is more need for life insurance on the part of an individual who has responsibilities, children, dependents to support in event of their demise, than there is for an individual who is single and has no family that would be put to dire need if they should die.

Senator HART. I think it would be well, then—if there is no objection—to print in the record the two pages to which I have made reference, because the reader of the record is limited to just this exchange of questions and maybe wondering exactly what it was involved. I think printing the two pages will put it into pretty fair perspective.

Mr. BIERSEBACH. There is certainly no objection.
(Documents follow. Testimony resumes on p. 1053.)

RISKS COMMITTEE

INSPECTION REPORTS—GENERAL INSTRUCTIONS

I. *Routinely Required*.—Ordered by Field Office.

1. Disability Income.
2. Business Overhead Expense.
3. Accidental Death. (If field offices order for other plans, point out their error to them.)

II. *Not Routinely Required*:

In the areas where routine inspection is not required, there are certain individuals who because of their associates, their environment or their occupation would be inspected regardless of the benefit or plan applied for. Unfortunately, it is not always easy to pick these out. In the past we attempted to catch them by inspecting all applicants who worked at the type of job we felt would draw them. Studies however, have shown this approach to be too general and we are ordering far too many unnecessary inspection reports.

Thus, we have a problem: "How can we cut out the unnecessary reports without eliminating one of our very valuable underwriting tools?"

The answer, we believe, lies in a refinement of current practice. Continue to watch those occupations which tend to be conducive to poor environment, habits or morals, but then be more selective—or to be more explicit, exercise more individual judgment within these occupations. For example, one of the occupations currently requiring routine inspection is a waitress serving liquor. This means that you would routinely order an inspection on anyone in that occupation. Under our new approach, you'd use the occupation as a "red flag" but base your decision as to the need for an inspection report on further details. If she were working in a first class restaurant or hotel, you wouldn't order an I.R. However, if she were working in a corner tavern or for a night club you probably would need an inspection report. You wouldn't order an I.R. if she were a housewife helping her husband support a couple of kids, but you might if she were single or a divorcee or separated, particularly where no family is involved. Age is also a factor to consider. If she is young and unattached you'd be more apt to order an inspection. With this background here is a list of occupations you should look for. This is not all of them, but they typify what you're looking for. When you run across them, use what other facts you can uncover to decide if an inspection should be required.

A. *Individuals to watch*.

1. Persons working where serving alcohol is a large percent of business, such as bartenders, cocktail waitresses, check girls, cigarette girls, entertainers, hostesses, or saloon keepers.
2. Persons whose occupation is conducive to moral criticism such as artists, models, male hair dressers, etc.
3. Persons with low incomes conducive to poor living standards and environment, usually class 4 such as laborers or other unskilled workers performing heavy manual labor.
4. Persons with high occupational hazard including most class 4's and all class 5's.
5. Applicants for Hospital Coverage over age 55.

B. *Other factors to look for in deciding whether or not an inspection should be ordered*.

1. Is applicant married with children and responsibilities or single without responsibilities?
2. Is income high enough for decent standard of living or low inviting poor environment?
3. Is place of employment first class or low class and conducive to poor environment, habits or morals?

4. Is agent well acquainted with applicant or did applicant come to agent for coverage or was application taken on canvass?

5. Has any other insurer taken adverse action?

Because this type of case presents peculiar problems, discuss all developments with your Assistant Manager. Inspection reports are a constant problem because of curiosity. If case is one which may arouse curiosity of other employees, the IR should be removed from file and held in Department files until 30 days after the policy is issued.

Mr. O'LEARY. Mr. Bierschbach, yesterday when we were questioning the representative of the Metropolitan, there was reference to the "red star" district. In the colloquy that was developed with those gentlemen, they acknowledged, in effect, that there were certain geographical areas that they took into consideration for underwriting purposes.

They took special pains to point out that these were not just necessarily intercity districts. That there were districts that they felt exposed them to more risks. And they agreed to furnish us with a list of the districts that they have as "red star" districts.

My question is: "Do you use where a person lives in any manner or fashion as an underwriting guide with respect to individual health insurance?" Is that something that you would take into consideration at all?

Mr. BIERSCHBACH. To the best of my knowledge, the geographical location in which an individual lives would have no effect on our underwriting. We do not have any geographical areas centered out as being areas that we want to avoid.

Mr. O'LEARY. I notice that—making reference to the page 310—A that Senator Hart utilized a few moments ago—there are a couple of entries such as, under category A, "individuals to watch." There are then five entries. The third entry is: "Persons with lower incomes conducive to poor living standards and environment, usually class 4, such as laborers or unskilled workers performing heavy manual labor."

Can you tell me just exactly what that entry means, what you are looking for? And why?

Mr. BIERSCHBACH. The primary purpose of that would probably be the accident hazard.

Mr. O'LEARY. The reference, "poor living standards and environment"?

Mr. BIERSCHBACH. All right. We would be concerned about an individual who lived in a home where the sanitary conditions were not good. We would be concerned if, let us say, it was an unhealthy atmosphere in the home. That would be true regardless of where that home might be located.

Mr. O'LEARY. Well, would an inspection report—if I am a laborer or an unskilled worker performing manual labor, would someone from your company go out and take a look at my home, such as inspections done by fire insurance companies, to see what the place looked like?

Mr. BIERSCHBACH. Not an employee of our company per se. We might have an inspection report run by the inspection company.

Mr. O'LEARY. The inspection company, would that be like a retail credit bureau?

Mr. BIERSCHBACH. Yes, sir.

Mr. O'LEARY. And they would go out and—let us say I live in a run-down individual dwelling, what would they report back to you?

Mr. BIRSCHBACH. I believe they would not make any evaluation just on the exterior appearance of the house.

Mr. O'LEARY. What would it be based on?

Mr. BIRSCHBACH. They would probably come to the door and knock and ask to visit with you and /or your wife and would get some impression as to whether the house was tidy.

Mr. O'LEARY. And if the house is untidy, you feel that that would make me a poor risk for health insurance?

Mr. BIRSCHBACH. I believe that if it was downright filthy and unsanitary, it could; yes. If there were toys on the floor with children playing, certainly not.

Mr. O'LEARY. So let us assume that it is downright filthy. Does that mean I do not get the insurance or does that mean I pay more?

Mr. BIRSCHBACH. Chances are it would be rated, not that it would be declined.

Mr. O'LEARY. What else, if anything, would be looked for?

Mr. BIRSCHBACH. I cannot think of anything else that would be looked for, Mr. O'Leary.

Mr. O'LEARY. If I come to you and apply for health insurance individually, what check, if any, is run on me to see whether or not I—I assume there is something in the application form as to whether or not I have applied to other companies?

Mr. BIRSCHBACH. Yes.

Mr. O'LEARY. And if I indicated in that form, "yes," I have applied to other companies, what, if anything, do you do with respect to the companies that I have listed?

Mr. BIRSCHBACH. Our concern there is that we would not want to issue coverage on an individual who already has existing coverages in several other companies because of over-insurance.

Mr. O'LEARY. You will have to help me there. Assuming I am applying for an individual policy, would my benefits be coordinated anyway, or not necessarily?

Mr. BIRSCHBACH. Our individual policies do not coordinate.

Mr. O'LEARY. So you would be concerned as to whether or not I might be a chronic malingerer who is trying to get over-insurance and then use these facilities and collect on two policies?

Mr. BIRSCHBACH. Yes, sir.

Mr. O'LEARY. Assuming that I am listed, what do you do? Go to the other company and say, "What kind of coverage does this guy have?"

Mr. BIRSCHBACH. No; we go back to you, sir.

Mr. O'LEARY. Go back to me? Ask me what I have.

Mr. BIRSCHBACH. Yes, sir.

Mr. O'LEARY. And let us assume I have a group policy, then on that basis I would be declined an individual policy from you?

Mr. BIRSCHBACH. It would depend on the type of individual policy you were interested in buying from us.

Mr. O'LEARY. I see.

Mr. BIRSCHBACH. And it would also depend on the extent of your group policy.

Mr. O'LEARY. Right. What if I do not list another company on there? What sort of a check is made to find out whether or not I have another policy someplace else?

Mr. BIERSCHBACH. There is no way we could check to find out if you had another policy.

Mr. O'LEARY. Your company does subscribe to the Medical Information Bureau, does it not?

Mr. BIERSCHBACH. Yes, sir.

Mr. O'LEARY. Is that utilized in any fashion as a check to see whether or not I have insurance with somebody else?

Mr. BIERSCHBACH. I will answer your question as well as I can but I will want to verify the accuracy of my answer. I think if you applied for another policy in another company and a policy were issued and there were no problems, I do not believe there would be an entry in MIB. I would have to verify that, sir.

Mr. O'LEARY. Well, as I understand it, the information that MIB has comes from either the individual life applications or individual health applications.

Mr. BIERSCHBACH. More so from the former than the latter.

Mr. O'LEARY. More so from the former than the latter. What I am trying to get at is what sort of procedure do you have, or to what extent do you engage in exchanging information with other insurance companies, and how does that situation come about?

Mr. BIERSCHBACH. Well, it would be pretty rare that we would exchange information with other companies. If you have some specific ideas in mind, I could maybe answer.

Mr. O'LEARY. Well, I am looking at page 380 of your Health Insurance Underwriting Supplement, entitled "Inquiries to Other Companies." And I will just read you the first paragraph.

Form 28-PF, Request for Details, is used whenever we request information from another insurance company. It has been our practice up to now to advise the other company about amount and type of insurance applied for with us, the date of the last MIB report, and any unfavorable information on file at the time of inquiry.

Because of recent changes in the law, we may no longer provide such information without the proper authorization.

And then, at the bottom of the page, there is an entry. It says:

In responding to an inquiry from another company for information from our files, we must have a signed authorization before releasing any information.

I assume that that means that if another insurance company wants to get information from your files, they must forward to you an authorization signed by whoever it is applying for insurance with that company?

Form 28 P.F., Request For Details, is used whenever we request information from another insurance company. It has been our practice, up to now, to advise the other company about amount the type of insurance applied for with us, the date of the last M.I.B. report and any unfavorable information in our file at the time of inquiry. Because of recent changes in the law, we may no longer provide such information without proper authorization.

The following procedure will be used whenever we are requesting information direct from another company:

1. A signed authorization (or copy thereof) must accompany each request.
2. Identification information only will be given on our request form. This includes the date, our File number, Name, Date of Birth, Birthplace, Occupation and Residence Address.

3. In sending or answering inquiries, it is imperative that we neither indicate the tentative or final action on our file nor request the other company for theirs.

If no authorization slip accompanies the application file, the underwriter must request one from the agency before sending an inquiry to another company.

Such a request for signed authorization should be marked on the underwriting sheet as a 35J requirement.

In responding to an inquiry from another company for information from our files, we must have a signed authorization before releasing any information.

Mr. BIERSCHEBACH. That is correct.

Mr. O'LEARY. Saying that he has no objection?

Mr. BIERSCHEBACH. Correct.

Mr. O'LEARY. What sort of a situation would be?

Mr. BIERSCHEBACH. It could arrive if on the application for insurance there was no indication of any particular impairment; and if we were to query MIB and find out that there was a report of some particular impairment; and go back to the insured and get no verification of it; we might then go back to the MIB to give a request for details.

We do not know who the company is that put the information in there. MIB would forward our request to this company that put the code in the first place and say that Occidental is asking for the information on the code, and then that other company could come back to us and say, "If you will supply signed authorization to get the information, we may give you some of the information."

Mr. O'LEARY. And I take it that would generally be a medical condition or some sort of impairment which would trigger the inquiry.

Mr. BIERSCHEBACH. Yes, sir. Incidentally, we could not then act on the information we got from the other company. We would have to verify it ourselves.

Mr. O'LEARY. Right. Now, I am now referring to page 1080, Subject: MIB Code Procedure. The bottom of the page, Roman Numeral III, Request for Code Details.

Request for MIB Code Details must be held to a minimum. No details should ever be requested until all other facilities have been exhausted. If it becomes necessary to request code details, use the M-101 and make the notation, "Request Code Details," give symbol and date of report.

The next paragraph goes on,

Check rules, prepare form B-15 and file with the Index Department. Index will be transmitted request by date by phone to MIB. Boston. Boston will request the information from the member company involved. This system should result in much faster carrier handling of these requests.

I take it that that is a situation where someone has applied with your company and you have then transmitted a request for details to MIB; MIB goes to the other company involved. There is a note here at the bottom which says, "Remember, we must always have a signed authorization in our file before requesting code details." And you have the authorization and you are asking the other company to provide you, through MIB, with whatever information it is they have with respect to this applicant's condition or impairment?

The R.U. System is a method by which the underwriter may flag certain cases so that they will not be reinstated without underwriting review.

Since all M.I.B. codes on issues, claims, declines, P.S.'s or recent changes will be picked up by Index and be referred to the underwriter on reinstatement, the use of the R.U. System becomes very limited.

The R.U. System will be used only where no code can be reported to M.I.B. but where the condition indicates a reinstatement should be underwritten.

If the conditions is found in connection with a claim, change, decline or P.S., the R.U. System will not be used.

Underwriters are expected to familiarize themselves completely with coding procedures. They should know when and how to report codes, how to interpret

them and *how to use them properly*. They are cautioned to observe all the rules in Appendix A, pages 21, 22 and 23 of the M.I.B. Official Code List of Impairments.

I. General Information

The Medical Information Bureau (M.I.B.) is a non-profit, unincorporated association formed to conduct a confidential interchange of information between officers of the member life insurance companies. The Executive Committee has designated the Recording and Statistical Corporation as servicing agent for the Bureau. In Occidental, a tape checking system is maintained on U.S. and Canadian impaired risks.

II. Reporting Impairments

Complete instructions are to be found in the M.I.B. Official Code List of Impairments. This includes special instructions relating to the Fair Credit Reporting Act, shown opposite page 3 of the Code book. *In no case should the reporting of a code be delayed longer than 30 days after receipt of information in the Home Office.*

Life and Health Underwriters will not report any M.I.B. code marked "dis" (Discretionary) if the impairment is found only on Health new business or Health Claims. However, where there appears to be a particularly bad situation such as 275 or 024, refer the file to Dr. Vaughan for his authority to report the code.

III. Request for Code Details

Requests for M.I.B. Code details must be held to a minimum. Code details should never be requested until all other facilities have been exhausted. If it becomes necessary to request code details, use the M-101 and make the notation "Request Code Details", and give symbol and date of report.

Attach a routing tag (M-406) marked "Request for Code Details" and move the file and request via N.B.C. to the Medical Department. They will check rules, prepare Form B-15 and move file to the Index Department. Index will transmit request by Data Phone to M.I.B. Boston. Boston will request the information from the member company involved. This new system should result in much faster handling of these requests. If no reply, Index will re-transmit to Boston in 10 days. At 3rd follow-up, underwriter will either take action or reorder code details.

If another requirement is ordered at same time code details are requested, the routing tag should be marked (1) Typists (2) Medical Department—Code Details.

NOTE.—Remember we must *always* have a signed authorization in our file before requesting Code Details.

IV. Verification of Code Information

Generally, the method of M.I.B. code verification will vary according to the type of code as follows:

1. Medical impairment (physical history or condition)—make an attempt to verify by rechecking with agent, ordering Attending Physician's statement, examination or other *medical* information.

2. Supplementary impairment (habits, morals, financial or other nonphysical hazard)—make an attempt to verify by ordering an inspection report.

These rules will apply even when the code indicates an uninsurable condition unless we have other verifying file information.

V. Use of M.I.B. Information

The General Rules of the Executive Committee of the M.I.B., revised March 5, 1971, includes Rule 14 which reads as follows, "The information received through the Bureau shall not be used in whole or in part for the purpose of serving as a factor in establishing an applicant's eligibility for insurance".

The application of this rule means that:

M.I.B. information may properly be used only as an alert signal indicating what to look for and where, and as a supplement to a member's own medical examination, inspection or other information.

Occidental has interpreted this ruling as follows:

"M.I.B. codes alone may never be used as the basis for underwriting action, or estimates of probable action."

VI. M.I.B. Codes—Confidential Nature

Codes are confidential in nature and neither the details nor the fact that information was obtained from a code bureau is to be disclosed to anyone except an authorized person within the Company (Authorized persons are those who have possession of code books in an official capacity).

As many persons within the company who handle the file after it has been processed by the Underwriting Department are not authorized, no written interpretation of codes is to be made in the file.

Mr. BIERSEBACH. That is correct. The reference to all those codes is because we have the underwriters in one of the departments and the clerical people in the other, and this is just form.

Mr. O'LEARY. This procedure seems to have been in operation since 7-7-71, so I would assume that this is the same procedure that is in effect now?

Mr. BIERSEBACH. That is correct.

Mr. O'LEARY. And then under roman number IV, it says, "Verification of Code Information." Generally the method of MIB code information will vary according to the type of program as follows:

One, medical impairment, physical history or condition, make an attempt to verify by rechecking with agent, ordering physician's statement, examination, medical information.

Two, supplementary impairment.

And then in parenthesis it says,

Habits, morals, financial or other non-physical hazards. Make an attempt to verify by ordering an inspection report.

Can you give me an illustration of what is meant by "habits and morals" and "non-physical hazards"?

Mr. BIERSEBACH. If I can think of a good example for you. If there were any indication that an individual had been, let us say, in trouble with the law, repeated times, and we might want to get information on that.

Mr. O'LEARY. Why would that be of concern to you in relation to a health policy whether or not a person is a good or bad risk as far as health is concerned?

Mr. BIERSEBACH. Well, I think if it were someone with the Mafia, we might be a little concerned about writing a health insurance policy on him.

Senator HART. If what?

Mr. BIERSEBACH. If a person were in the Mafia, I think we might be a little bit concerned about writing a health insurance policy on him.

Mr. O'LEARY. Let us assume that I am not Joe DeGallo and I do not have any felony convictions. I have been engaged in no shoot-outs—

Mr. CHUMBRIS. He would give you a policy.

Mr. BIERSEBACH. I doubt that we would get any morals code on you then, sir.

Mr. O'LEARY. Well, then, let us assume that I am a—habits, morals—I am a con man. I mean, is it the kind of racket? Do you take that into consideration?

Mr. BIERSEBACH. I think if a person had been in and out of bankruptcy on several occasions, we would be concerned about writing a policy.

Mr. O'LEARY. That would be a factor to consider as far as his health is concerned?

Mr. BIRSCHBACH. Well, the feeling there might be that he might be paying premiums out of moneys that are really tied up by bankruptcy proceedings and we would end up having to refund the premiums, after having already provided coverage.

Mr. O'LEARY. What about a divorced person, would that be a factor you might take into consideration in either deciding whether or not to write me or what rate to charge me?

Mr. BIRSCHBACH. I do not think so.

Mr. O'LEARY. Just one more. I am looking at page 615, Health Insurance Underwriting Supplement. The last entry on this page reads:

Watch carefully for indications of transiency. Be selective, especially with unmarried or divorced women without families.

Is that something you would take into consideration as to the kind of risk that a person might be?

1. Regular Limits

2. Inspection on all Applications

Watch carefully for indications of transiency.

Mr. BIRSCHBACH. I didn't get all of your statement.

Mr. O'LEARY. "Watch carefully for indications of transiency. Be selective, especially with unmarried or divorced women without families." Would you consider unmarried and divorced women without families a high risk, poorer risk, for health insurance?

Mr. BIRSCHBACH. Transiency, I think, is the key factor there in that if a person does not have a family, is drifting around a lot, the factors we are concerned about here are the persistency of the business.

Mr. O'LEARY. What about Gloria Steinberg, would you write her?

Mr. BIRSCHBACH. Why not?

Mr. SHARP. Mr. Birschbach, just one more of these health insurance underwriting supplements. Subject: Pregnant Wives and Family Coverage. And the underwriting health coverages were, family to be included, the following procedure must be observed in pregnant wives.

One, if the wife is pregnant more than three months, get the attending physician's report to determine if the pregnancy is proceeding normally.

Two, if there are any complications of pregnancy, postpone coverage on wife until after childbirth.

Now, in your statement, you tell us that Occidental is concerned with the health needs of Americans. Now, why would you want to postpone coverage on the wife until after childbirth, particularly when prenatal care is so important?

In underwriting Health coverages, where a family is to be included, the following procedure must be observed on pregnant wives:

1. If wife is pregnant more than three months, get AP report to determine that pregnancy is proceeding normally.

2. If there are any complications of pregnancy, postpone coverage on wife until after childbirth.

Mr. BIRSCHBACH. I think you would agree, Mr. Sharp, that if a woman is pregnant and there appear to be some complications, there is probably—or there is possibly—an increased probability of there being some detriment to her health, and in voluntary insurance programs what one tries to do is put people in categories of risks where all the

people in the group are in a category that have the same probability of experiencing the event that will give rise to a claim. This does not mean that we want to decline them from insurance. We want to put them into the proper group.

Mr. SHARP. In what group would you put a pregnant woman that may have some complications? What type of group and how would you charge that family? I assume this is a group policy?

Mr. BIERSCHBACH. This would not be a group policy.

Mr. SHARP. It is an individual policy written on a family and you are going to exclude now, or postpone, coverage on the wife, when would you cover her?

Mr. BIERSCHBACH. After the delivery of the child.

Mr. SHARP. And if there were complications or the family needed medical help, and financing for that medical help, they would not be eligible under your policy, is that correct?

Mr. BIERSCHBACH. If they were waived out, yes, sir.

Mr. SHARP. If you waived her out?

Mr. CHUMBRIS. If they were what?

Mr. BIERSCHBACH. If they were waived out.

Mr. SHARP. Do you waive out all of them?

Mr. BIERSCHBACH. No, no. If we decided to postpone the coverage on the wife until after delivery of the child, there would be no benefits paid upon the delivery of the child.

She could reapply after the delivery of the child and be fully covered.

Mr. SHARP. That is because from a business standpoint, you are in business, and I am not being critical, you would have to pay claims, isn't that what it amounts to?

Mr. BIERSCHBACH. Well, as I said a few moments ago, in a voluntary insurance system, you do not willingly go on a risk immediately before a known claim. You are insuring against an unknown. That is a known.

In life insurance, for example, you would not knowingly insure a person as he was about to leap off a building.

Mr. SHARP. Let me ask you—say we have a doctor that is very sympathetic to the woman's condition. He gives you a report that states that as far as he is concerned, the pregnancy is proceeding normally. How do you check this?

Do you have a feeling sometimes, in this business, that, perhaps, the doctor may want to be sympathetic to the plight of the patient, also the doctor might want to be paid, and does this kind of make—I am trying to, without saying the word, make doctors sort of, well, fudge the thing a little bit—the doctor suspect in your eyes?

Mr. BIERSCHBACH. No, sir. If the doctor told us the pregnancy was proceeding routinely, we would not be suspicious of the doctor.

Mr. SHARP. Thank you. That is all I have.

I was wondering, you submitted to the subcommittee your contract performance review reports as a Medicare intermediary.

Mr. BIERSCHBACH. Yes, sir.

Mr. SHARP. Under the part B program, is that correct?

Mr. BIERSCHBACH. Yes, sir.

Mr. SHARP. And you submitted an on-site audit report carried out in 1970—July 20 to 24, 1970. It was a contract performance review report.

You have also submitted today to the subcommittee a document entitled, "Meeting between the Bureau of Health Insurance Regional Office, Social Security Administration, San Francisco, and Occidental Life Insurance Company, Los Angeles, California, May 5, 1972." And among the representatives I notice Mr. A. B. Halverson, senior vice president.

Now, on the last page of this—it is not numbered, I am sorry to say—of the document you submitted—I guess it would be page 7 is numbered—

Interest or reflect improper money management by OLIC. Occidental was following SSA's specific instructions in handling its letters of credit instructions.

VII. Administrative Costs

A. HEW Audit Recommendations and BHI Follow-Up Review Findings

1. After the close of HEW's Audit's field work, Occidental revised its calculations of allocated administration costs, resulting in a reduction of \$3,801.00 in 1968 and an increase of \$3,832.00 in 1969. Both OLIC and HEW Audit agreed to this net increase of \$31.00.

2. HEW Audit questioned Occidental's claimed public relations costs of \$6,586.00 in 1968 and \$6,596.00 in 1969. In the BHI review, additional information was obtained which substantiated Mr. Dick Trueblood's involvement in Medicare activities. The amounts in question represent approximately 13 percent of his salary and office expenses. Since Medicare did benefit, it was agreed this was an allowable expense.

3. HEW Audit questioned \$6,741.00 in Planning Department Costs. Based on a review by BHI, it was determined this was a proper cost.

4. HEW Audit felt \$1,490.00 was a re-organizational cost and not allowable. Based on the BHI review, it was determined this was an allowable cost.

5. HEW Audit questioned \$7,229.00 of claimed telephone expenses. Based on a BHI review, it was determined that the correct amount to be questioned was \$6,697.00.

6. The audit report concluded that "Classified Distribution" salaries should be considered as direct salaries in computing the percentage of indirect expenses to be allocated to Medicare. As a result, the auditors questioned \$12,683.00 in 1968 and \$17,793.00 in 1969. BHI has reviewed OLIC's allocation procedures, and concludes that a portion of "Classified Distribution" salaries should be considered direct salaries. At the time of the meeting, the amounts to be questioned had not yet been computed, but it was estimated that they would total about \$2,000.00 in 1968 and \$8,000.00 in 1969. (On May 10, 1972, it was determined that these amounts would be \$2,148.00 and \$8,370.00, respectively.) Both BHI and OLIC concur that the matter of overhead allocation is judgmental to a degree, and that the positions taken by both HEW Audit and OLIC have merit.

B. Conclusion

BHI and Occidental both agreed to the amounts as discussed above.

Mr. BIERSCHBACH. Are you referring to the minutes of the May 5 meeting?

Mr. SHARP. Yes, I am sorry.

Mr. BIERSCHBACH. OK.

Mr. SHARP. Under Roman No. VII, it lists "Administrative Costs and HEW Audit Recommendations, Bureau of Health Insurance Followup Review Findings."

Nowhere in there—and please correct me if I am wrong—nowhere do we see in there anything dealing with the so-called statistical summary of the Occidental Life Insurance Co. contained in the contract performance review report, July 20–24, 1970.

In that statistical summary, they cite the cost per claim of handling these Medicare audits. Do you have that, sir, by the way?

Mr. BIERSCHBACH. The contract performance review report?

CONTRACT PERFORMANCE REVIEW, OCCIDENTAL LIFE INSURANCE CO., LOS ANGELES,
CALIF., JULY 20-24, 1970

List of participants

Calvin Beachum, Contract Performance Review Branch, Division of Intermediary Operations, Bureau of Health Insurance.

Charles Jezek, CPRB, DIO, BHI.

Anthony Lovecchio, CPRB, DIO, BHI.

Leonard Peshkin, Medical Insurance Reimbursement Branch, Division of Reimbursement, Bureau of Health Insurance.

John Taylor, Division of Systems, Bureau of Health Insurance.

Mary Daniels, Division of Health Insurance Studies, Office of Research and Statistics, SSA.

Harry Savitt, Division of Health Insurance Studies, ORS, SSA.

Plan of Report

This report consists of a summary evaluation followed by findings and related recommendations resulting from the onsite review of Occidental Life Insurance Company. Additional information pertaining to the various areas reviewed is on file in the Contract Performance Review Branch.

Except for the summary evaluation, the format of this report is of an exception type, i.e., in general, only areas requiring improvement and recommended methods of improvement are presented. This format has been adopted for administrative purposes and is followed in all performance review reports. No implication as to the overall level of the carrier's performance is intended or should be drawn solely from the extent and nature of the exceptions noted. However, a general evaluation of the overall level of performance of the Medicare operations is contained in the second section of this report.

Recommendations contained in this report are subject to budget limitations; supplemental fiscal approvals are to be obtained as appropriate in implementing recommendations.

I. STATISTICAL SUMMARY, OCCIDENTAL LIFE INSURANCE COMPANY

A. General

[Service area: 9 counties, Southern California, 910,000 beneficiaries; fiscal year 1970; budget, \$6,560,000; workload, 1,565,000; staff, 638 man-years.]

B. Workload data

	Quarter ending March 31, 1970	Current months		
		March	April	May
Receipts.....	441,004	145,322	151,690	141,430
Clearances.....	441,370	147,616	153,944	140,401
1490 Assignment rate.....	41.7	43.5	40.9	39.7
National.....	58.3	62.3	62.5	63.3
Investigation rate.....	6.9	8.2	8.2	6.8
National.....	9.3	8.4	8.3	8.5
Denial rate.....	5.9	6.5	8.6	11.1
National.....	6.7	7.0	6.9	7.1
Mean processing time.....	17.7	28.5	16.5	NA
National.....	26.4	32.6	29.6	NA
Median processing time.....	11.4	12.2	11.7	NA
National.....	17.8	22.4	18.2	NA
Pending (monthly average).....	73,723	69,775	67,521	68,550
Week's work on hand.....	2.1	2.1	1.9	NA
National.....	3.1	2.6	2.6	2.7
Percent pending over 30 days.....	7.6	8.5	8.2	7.5
National.....	23.4	25.7	27.5	27.9
Queries pending final reply as percent of total:				
Pending.....	19.4	18.4	15.9	20.6
National.....	18.7	21.9	25.9	25.2

C. Productivity

	Expenditures, fiscal year 1969	Fiscal year to date	
		July 1968- March 1969	July 1969- March 1970
Cost per claim.....	\$4.13	\$4.20	\$4.30
National.....	\$3.06	\$3.05	\$3.14
Production per man-year.....	2,087	2,009	2,277
National.....	3,046	3,062	3,392

Mr. SHARP. Yes.

Mr. BIRSCHBACH. Yes, I do.

Mr. SHARP. Good. They refer to the cost per claim, national, as well as your company. It states for Occidental, that the cost per claim for the period July 1969 to March 1970 is \$4.30, but the national average was \$3.14.

Now, could you explain to the subcommittee how your administration of Medicare can cost 30 percent more than the national average?

I am reading this because on page 20 of your statement you state that the present type of group insurance system and the privately administered Federal Medicare program is doing well, they are doing all right.

The possibility of success for such a privately administered program is indeed supported by the success of the present private group insurance system and the privately administered Federal Medicare program.

And I am wondering if your company has corrected the situation and how can you explain the 30 percent more per claim on the part of your company than the national average?

Mr. BIRSCHBACH. Mr. Sharp, I would like to say that there are a lot of things that go into evaluating the efficiency of the administration of a Medicare program. If you look under that same statistical summary—

Mr. SHARP. Yes, sir.

Mr. BIRSCHBACH. If you go up to "mean processing time" of the quarter ending March 31, 1970, Occidental's was 17.7 days; national average was 26.4. That is a service.

If you go down to "percent pending over 30 days," Occidental was 17.6; national average was 23.4 that is a service.

Then I would like to add to the "cost per claim" data that you read the fact that during the period of July 1971 to December 1971, our cost per claim has fallen from \$4.13 to \$3.72.

Mr. SHARP. Is that what it is now, sir?

Mr. BIRSCHBACH. That is what it was during the last—no, I am sorry—during the last 6 months of last year.

Mr. SHARP. Where is that shown in here?

Mr. BIRSCHBACH. That is not shown on that page. It is a subsequent report. Mr. Frost, do you have the data of that report?

Mr. SHARP. Are you saying that it has gone from 4.13 down to 3.60?

Mr. BIRSCHBACH. 3.72.

Mr. SHARP. Do you know what the national average is?

Mr. BIRSCHBACH. The national average has gone from 3.14 up to 3.31.

Mr. SHARP. So you are still above the national average?

Mr. BIRSCHBACH. We are still above the national average. Let me make one more statement on this and then I will let Mr. Frost add to it if he likes.

It is our opinion that when we set up our medicare system, we set it up to do as good a job in all respects as we could. We built in some controls that some of the other carriers did not build in—some of the intermediaries did not build in.

The HEW is now able to evaluate the jobs being done by the different intermediaries and are requiring some things from other—I am told they are requiring things from other intermediaries that we have

been providing all the way along. Ours are more expensive. As further requirements are put on other intermediaries, their costs are going up and our costs are, in fact, going down.

Mr. SHARP. Well, before Mr. Frost begins, I would like to continue with you a moment, please, if I may.

You pointed out the mean processing time, the intermediate processing time and the percent pending over 30 days. On the same sheet I notice investigation rate. That is the amount that you are spending to investigate per claim for the quarter ending March 31, 1970, as you pointed out, is 6.9, while the national average is 9.3. And at the same time, on the bottom of the page, it shows that the production per man-year for your company is 2,087, and the national, 3,046.

Now, this shows, does it not, that you are processing your claims very quickly; you are not spending much money investigating them; and it seems that too many man-years are being spent on cases handled, so you have a low rate of productivity and a high rate of cost per claim.

Doesn't this suggest to you that maybe too much is being invested—in the sense of being passed on, in the way of costs to the taxpayers—in the management and executive branch of your company?

I am sure you have a lot of people here getting these claims out very quickly. Your production per man-year is lower than the national average. Your investigation expense is lower and yet your costs are higher.

It is my understanding, and please correct me if I am wrong, that a certain percentage of your executives and managers—a certain percentage of their costs are allocated to the medicare program, and therefore the taxpayers will be paying for this. Do you see any other conclusion from these figures?

Mr. BIERSEBACH. Yes, I do, Mr. Sharp. In the first place, you indicated that this was—that the investigation data was an expense. It is not an expense, it is an investigational ratio.

Mr. SHARP. I am sorry. It is a rate per claim.

Mr. BIERSEBACH. And if you move over just to the next column, you will see that the rates are extremely close during the months of March and April. That sort of thing seems to fluctuate around considerably.

Mr. SHARP. What about May, sir?

Mr. BIERSEBACH. Okay, May. It goes back to the same sort of comparison that we had before, even closer.

What was the other item that you were—

Mr. SHARP. Production man-year.

Mr. BIERSEBACH. All right. The production per man-year figures for Occidental was 2,277. The national average was 3,392. For the last 6 months of last year, the production rate for Occidental had moved from 2,277 to 2,344, whereas the national average had fallen from 3,392 down to 3,309.

So there again it is a case of the Occidental having made improvements, whereas the national average has deteriorated somewhat.

You asked a question about allocation of the expenses. I do not have all the details on the allocation methods, although the HEW in their audit report did question certain matters and have now reconciled all differences and both parties were satisfied.

Mr. CHUMBRIS. Mr. Sharp, if you would yield for a moment. Just to get some balance on the questions and answers, now you are talking

about what your company is doing and Mr. Sharp is bringing about the national average.

Now, does it make a difference that you are operating in one certain part of the country and other companies are operating in other parts of the country? That would make a difference in the operating expenses.

For example, when we had the Blue Cross hearings, they prepared a chart. For example, in 1969, operating expenses for Blue Cross, at the top it is Alabama—6.8; Wilmington, Del.—4.4; Boston, Mass.—3.9; Montana, for example, 12.2. Well, those figures that were given there did not tell the whole story because as the witness would say that, for example, some of them had medical and surgical plans, others included reserves for maternity benefits, one excludes medical and surgical and extended benefits, so you just could not use those percentages saying that one State was higher than the other, unless you looked at the whole picture.

Now, my point here is, is there something in your operation that made you operate at \$4.30 one year and \$3.72 the next year? Maybe the next year would reflect something differently. That's the only thing, so that we can make this record a little more relative for whoever reads this record.

Mr. BIERSEHBACH. Yes, sir; there is something in the operation. It goes back to the question—to the reference you made, Mr. Sharp, regarding, what kind of a job we were doing.

In the Department of Health, Education, and Welfare bulletin, dated April 27, 1972, regarding the intermediary performance, they have put together an indicator and they call that the reasonable charge data.

This indicator, and I am quoting, "represents a nonstatistical measurement of carrier reasonable charge methodology. We have selected a number of key element carrier procedures which reflect the actual limitation of the Social Security Administration's more reasonable charge instructions." And they give more details about it.

And they rated the various intermediaries and what kind of a job they do in that regard. Occidental rates No. 1.

Mr. SHARP. You rate No. 1?

Mr. BIERSEHBACH. Yes, sir.

Mr. SHARP. Based on these records?

Mr. BIERSEHBACH. Yes. Based on this record and this reasonable charge and what sort of job we are doing about controlling charges.

Mr. SHARP. Mr. Chumbris raised the point that it could be a geographical differentiation—

Mr. CHUMBRIS. I just used that as an example.

Mr. SHARP. I just wanted to point out from this audit report the overall summary, and I will quote: "The Occidental Life Insurance Co. is the part B carrier for a service area composed of nine counties in southern California containing 910,000 beneficiaries."

Now—please correct me if I am wrong—it says that:

The carrier has demonstrated an ability to process claims on a timely basis with the exception of claims originating in San Diego County.

Mr. BIERSEHBACH. Can I ask you what you are reading from?

Mr. SHARP. I am reading from Contract Performance Review, Occidental Life Insurance Co. of California, Los Angeles, Calif., July 20–24, 1970.

Mr. BIRSCHBACH. All right, thank you. I have it.

Mr. SHARP. I am sorry. I should have said it. I am reading from page 3. At the top of the page it says, "Overall summary," and it seems from reading this, at face value, the geographical area under consideration here was southern California, was that correct, sir?

Mr. BIRSCHBACH. Yes, sir.

Mr. SHARP. Thank you. Now I would like to move onto another area. If you like, we will submit for the record the entire Contract Performance Review Report as well as the information you supplied to the subcommittee.

Mr. FROST. Mr. Chairman, could I point out that seven counties were added on a very recent basis. In January 1, 1970, Occidental—

Mr. SHARP. Seven counties?

Mr. FROST. Seven counties were added bringing us to a total of nine. That is quite a load on the company, beginning January 1, 1970—

Mr. SHARP. Where were these counties?

Mr. FROST. Southern California. Seven were added. We started with two and ended up with nine. The report from which you are reading, on page 3, it finally culminates after some suggestions and recommendations—all of which are of a very minor nature—that this carrier, after making these very minor corrections—not any major corrections, just minor corrections—will achieve a very high level of performance which keys back in to the No. 2 figure that we gave you.

Mr. SHARP. I am not quarreling with that. That is why I said we would put the whole thing in the record. But, let us make this point right here and now, whose opinion is that? Is that the opinion of the Bureau of Health Insurance of HEW?

Mr. BIRSCHBACH. I believe so.

Mr. SHARP. OK. And would you also supply for the record, the ratings or the rankings—you know, you read us some rankings and where you stand, and who these other carriers are? Would you happen to know the criteria used?

Mr. BIRSCHBACH. The description of the criteria is complete. I think we can just give you a complete report.

Mr. SHARP. Thank you. We would appreciate that, so that we would have a complete record.

(Documents follow. Testimony resumes on p. 1073.)

OCCIDENTAL LIFE OF CALIFORNIA,
Los Angeles, Calif., June 16, 1972.

The Honorable PHILIP A. HART,
Chairman, Subcommittee on Antitrust and Monopoly, Committee on the Judiciary, United States Senate, Washington, D.C.

DEAR MR. CHAIRMAN: During the course of my testimony before the Subcommittee on Antitrust and Monopoly, I made reference to a Department of Health, Education, and Welfare bulletin dated April 27, 1972, entitled "Part B Intermediary Letter No. 72-10" and referred to a table in that bulletin which we felt was of special significance in evaluating Occidental's performance as a Medicare administrator. The complete description contained in that bulletin of this particular indicator of performance is as follows:

"Reasonable Charge Data.—This indicator represents a nonstatistical measurement of carrier reasonable charge methodology. We have selected a number of key elements of carrier procedures which reflect the actual implementation of SSA reasonable charge instructions. The rating scale weighs the carrier's past customary and prevailing charge screens, together with the overall condition of their screens and the timeliness of implementation. Separate point values were assigned where charges are separated for individual localities and specialty

charge screens. The adequacy of the methodology for durable medical equipment, prosthetic devices, and ambulance screens is also considered. In addition, carriers' efforts in collecting 1970 data and refining this data with non-Medicare charge experience was also measured. These latter factors were deemed vital in judging a carrier's systems capability in implementing the new reasonable charge procedures.

"It should be noted that this indicator furnishes an evaluation of carrier efforts to comply with SSA instructions up to June 30, 1971. Our analysis of carrier screens after July 1, 1971, is not yet complete, since additional information on this update is required."

Attached is the table to which the above description applies and to which my testimony referred.

Sincerely yours,

RAYMOND A. BIRSCHBACH.

*Table 1f—Twelve-Month Composite for Reasonable Charge Compliance
October 1970–September 1971*

<i>Rank and carrier</i>	<i>Points</i>	<i>Rank and carrier</i>	<i>Points</i>
1. Rhode Island BS-----	48	7. Colorado BS-----	36
1. Connecticut general-----	48	7. New Hampshire-Vermont BS--	36
1. GHI -----	48	27. Kansas BS-----	24
1. Occidental -----	48	27. Missouri-Kansas BS-----	24
1. Texas BS-----	48	27. Arkansas BS-----	24
1. Prudential -----	48	27. Nationwide -----	24
7. Illinois BS-----	36	27. Travelers -----	24
7. Maryland BS-----	36	27. UMS -----	24
7. South Carolina BS-----	36	27. Mutual of Omaha-----	24
7. Indiana BS-----	36	27. Utah BS-----	24
7. Metropolitan -----	36	27. Delaware BS-----	24
7. Michigan BS-----	36	27. Massachusetts BS-----	24
7. Continental Casualty-----	36	27. Alabama BS-----	24
7. Pennsylvania BS-----	36	27. Minnesota BS-----	24
7. California BS-----	36	27. Milwaukee, Wisconsin BS---	24
7. Union Mutual -----	36	27. Montana BS-----	24
7. Puerto Rico BS-----	36	27. South Dakota BS-----	24
7. Pan American-----	36	42. Buffalo BS-----	12
7. Oklahoma DPW-----	36	42. Florida BS-----	12
7. Aetna -----	36	42. Madison, Wisc. BS-----	12
7. Equitable -----	36	42. North Dakota BS-----	12
7. General American-----	36	42. Washington BS-----	12
7. D.C. BS-----	36	47. Rochester BS-----	0
7. Iowa BS-----	36		

NOTE: Total possible points 60.

CONTRACT PERFORMANCE REVIEW—OCCIDENTAL LIFE INSURANCE COMPANY OF CALIFORNIA, LOS ANGELES, CALIF., JULY 20–24, 1970

II. OVERALL SUMMARY

The Occidental Life Insurance Company is the Part B carrier for a service area composed of nine counties in Southern California containing 901,000 beneficiaries.

For the quarter ending March 1970, the carrier had a total of 441,004 claims receipts with clearances of 441,370 and a monthly average pending of 73,623. Occidental ranks far below the national averages in mean processing time and cases pending over 30 days. For the quarter ending March 1970, the mean processing time was 17.7 days compared to the national average of 26.4 days. The percentage pending over 30 days was 7.6 percent while the national average for the same period was 23.4 percent.

The carrier has demonstrated an ability to process claims on a timely basis with the exception of claims originating in San Diego County. Claims from this area requiring medical review are referred to the San Diego County Medical Foundation. This procedure has caused considerable delays in claims processing times.

The carrier's operating costs are high as reflected by the unit cost per bill of \$4.30 compared to \$3.14 for carriers nationally and by the ratio of administrative expenses to benefit payments of 8.55 percent.

The carrier's average production per man-year for the first 9 months of FY 1970 was 2,277, substantially lower than the national average of 3,392.

In the opinion of the review team, the critical problems of costs and productivity are due in part to the carrier's policy of having the regular claims examiners review and correct all of the EDP rejects, clerical errors, and potential duplicate payments. This procedure represents about 20 percent of the files handled daily. Also, there is extensive activity in fulfilling requests for the claims history file which is not always necessary to process the claim.

The carrier has several deficiencies in the reasonable charge areas, particularly in the methodology used for the retention and assimilation of data for injections, durable medical equipment, and ambulance service.

The recommendations contained in this report, particularly those concerning claims processing and reasonable charges, when implemented should, in the team's opinion, enable the carrier to achieve a very high level of performance.

III. CLAIMS PROCESSING

A. FINDING

On January 1, 1970, the carrier assumed responsibility as Medicare carrier for 7 counties in Southern California, an area previously serviced by the California Blue Shield. At the time of the review, the carrier was receiving at least 300 claims daily from Blue Shield. These claims originating in the seven county area, were erroneously mailed to Blue Shield, thus causing considerable delay in processing.

Recommendation

The carrier's professional relations staff should take steps to assure that claims submitted from the newly acquired service area are sent directly to Occidental.

B. FINDING

The carrier's regular claims examiners are handling all of the claims process rejects. These rejects are EDP exceptions, clerical errors, and potential duplicate payments. The volume of these rejects represents about 20 percent of the daily workload reviewed by the examiners.

Recommendation

The carrier should consider establishing an exception unit to review the rejects, thus freeing the regular examiners from spending time correcting clerical errors. The salary range of the exception reviewers would probably be lower than that of the regular examiners and this move should result in increased productivity and lower unit costs in the claims process. Carrier management can be kept apprised of examiner error frequency by reviewing the periodic error statements of each examiner.

C. FINDING

The carrier has been experiencing considerable delays in processing certain claims from the San Diego County area handled under an agreement entered into by California Blue Shield with the San Diego Foundation for Medical Care. The agreement requires the carrier to submit certain claims to the Foundation for a prepayment review of utilization and covered services. At the time of the review, there were approximately 3,000 claims pending at the Foundation. A sampling of the pending claims showed that about 25 percent were over 30 days old, and some as much as 90 days. A sample review of the claims returned from San Diego showed 55 days as the average length of time each claim was out of office.

Recommendations

1. The carrier and the San Diego Foundation should immediately review the existing service arrangement to determine the actions necessary to achieve improved processing times by the Foundation.

2. If a reduction in processing time cannot be achieved, then the existing service agreement should be re-evaluated. The carrier has demonstrated the ability to process claims on a timely basis, and should be able to do so with claims from San Diego County. Among other things, they should consider the possibility of having the San Diego Foundation provide the carrier with its

screening criteria and thus enable Occidental to perform the prepayment review. The San Diego Foundation could still be involved in peer review, but on a post-payment basis.

IV. QUALITY CONTROLS

A. FINDING

The carrier has established utilization guidelines for use by the examiners in deciding which cases should be referred for review by the medical consultants. Records are kept of the total number of such referrals but no data are maintained as to the various reasons for referral, the number of ultimate denials, or payment reductions in these cases.

Recommendation

To properly evaluate the effectiveness of the utilization screening guides, the carrier should periodically analyze the types of referrals being made. Records should also be kept of the number of denials and payment reductions against the number of referrals for medical review.

B. FINDING

It was observed by the review team that some claims were being unduly delayed in the medical review area. Cases were found that had been referred 1 month previously but had not yet been reviewed.

Recommendation

The carrier should control the aging of cases in medical review and provide for the physician advisors to put in additional hours reviewing claims where significant backlogs of aging cases exist.

C. FINDING

The carrier is not compiling statistics on duplicate claim payments. When checks are returned to the carrier, the case is investigated to determine the type of overpayment, if a duplicate payment is identified, the reason is not recorded.

Recommendation

The carrier should begin compiling data on all identified duplicate payments. This would include the number, dollar amount, and reason. Analysis of this information should prove very useful to management in evaluating the carrier's duplicate payment prevention system and in determining whether any systems changes are needed to improve its capability.

V. REASONABLE CHARGE METHODOLOGY

A. FINDING

When additional information, received after a claim has been processed and a check has been issued, indicates that the initial code was understated, a manual determination is made in the difference between the amount that was reimbursed and the charge that is now ascertained to be reasonable. The additional amount is coded 8999 (miscellaneous) but the initial code and charge is not deleted from the computer data bank.

This practice of not deleting the understated code and original charge from the computerized data distorts the customary charge data and results in loss of data in the applicable procedure.

Recommendation

The carrier should consider the feasibility of erasing the initial erroneous entry and reapplying the actual charge to the proper procedure code for entry in the computer. The check in the allowable amount could still be manually dispensed.

B. FINDING

When an injection is not identified on the SSA-1490, the processor manually processes the claim item allowing \$1 for the injection.

Recommendation

Since it is possible that the carrier may be reimbursing a non-covered item (immunization, insulin, etc.) an attempt should be made to identify the injectable

material prior to processing the item. This would also lead to educating the physician to supply the necessary information at the time the claim is presented for payment.

C. FINDING

A composite prevailing limits list has been established based upon the price lists of the four largest suppliers of durable medical equipment. This list has not been distributed to any of the claims processors. In many instances the processors resort to memory in determining reasonableness of the charge. The supervisor appears to be the sole source of the listed information.

Recommendation

Copies of this listing should be distributed to all claims processors.

D. FINDING

Since the carrier has acquired the responsibility for processing claims in the seven additional counties, the concept of locality in the processing of claims for ambulance services has taken on the heretofore unconsidered dimension of distances. Ambulance rates within Los Angeles and Orange counties are regulated by statute. Claims processors are arbitrarily applying these same limits to ambulance services in the other seven counties. This could lead to denial of a claim or portion of a claim whose payment in full would otherwise be justified.

Recommendation

It is suggested that the carrier familiarize the claims processors with the concept of "locality" as discussed in section 6108.3C of the Part B Intermediary Manual. Further, the carrier should establish rate guides and screens for use in localities other than the two counties where rates are regulated.

VI. WORKLOAD REPORTING STATISTICS

A. FINDING

The Julian date of receipt entered in the payment record is incorrect. A computer status inquiry is created for each claim received, and initiates an MEA (Medical Expense Abstract) form for subsequent coding and computer control of the claim. Simultaneously, a voucher number which includes the date of computer entry is assigned to each claim. The latter date, which can be from 1 to 3 days after the date the claim was actually received, is used for all reports prepared by the carrier. Should the computer be in down status because of EDP problems, the time lag is greater. A more serious time discrepancy than the ones mentioned above results from clerical instructions which, under certain conditions, will void the original inquiry, claim records, and MEA and initiate a new inquiry which updates the date of receipt to the current date. The new date may be from several days to months later than the original receipt date. Processing times are understated as a result of this.

Recommendation

Immediate steps should be taken to correct these errors. The carrier should use the original date of receipt for all reports. This date should be the calendar date of receipt, originally stamped on the RFP, converted to the corresponding Julian date. Provisions should be made to maintain the original receipt date regardless of internal procedures.

B. FINDING

A review of claims and the related payment records disclosed incorrect data in various fields. Combining of unlike services and charges was noted on some of the processed claims. Whenever this occurs one or more of the following inter-related items may appear incorrectly on the payment record; largest single reasonable charge, number of charges, type of service, date of service, and place of service. A few cases examined showed inconsistencies in the number of charges and place of service. Several cases were incorrectly coded as type of service code "1" (medical care) for laboratory services and type of service code "2" (surgery) for radiology services. Management stated that these were due to coding errors rather than any systematic error in preparing payment records.

Recommendation

The reasons for these inconsistencies should be determined along with the extent of the resulting erroneous data. Steps must be taken to correct all inac-

curacies and insure acceptable EDP input for an accurate end product. Once this is achieved, constant review is essential to maintain a high quality product. Charges and services which are not exactly alike should not be combined. These should be entered separately on the MEA form so that correct data are shown on the payment records as specified in section 6532 of the Part B Intermediary Manual.

C. FINDING

Anesthesia charges are broken down to show time units with a charge assigned to each unit. This breakdown of time and charges appears incorrectly on payment records. The largest single reasonable charge would reflect the charge for one time unit instead of the total charge for administering the anesthesia; the single anesthesia service would show the number of time units required.

Recommendation

Management must coordinate clerical and computer operations to arrive at coding practices which will result in accurate computer input for the preparation of payment records.

D. FINDING

The carrier has implemented Revision No. 151 of the Part B Intermediary Manual and is converting its physician and supplier identification numbers to the respective social security or employer identification number, and assigning the one-digit type of physician/supplier code which relates to the identification number. The physician/supplier listing contained numerous inaccuracies in these items. Physicians and suppliers were assigned more than one identification number; the one-digit type of supplier/physician codes were inconsistent with the identification of the providers of services.

Recommendation

Immediate action must be taken to review the identification numbers assigned to physicians and suppliers to assure correct information in accordance with section 6532, pages 160.4-169.7 of the Part B Intermediary Manual. Only one social security number, assigned by the Social Security Administration, or one employee identification number issued to suppliers by the Internal Revenue Service must be used. The type of physician/supplier code must relate to the type of individual, group, or hospital performing the service. (Section 6532, pages 160.10-160.12 of the Part B Intermediary Manual)

E. FINDING

Specialty codes are incorrectly assigned and do not reflect the physician or supplier's actual specialty. Specialty code 49 (miscellaneous physician) and specialty code 25 (physical medicine and rehabilitation) appeared on the payment record listing more frequently than would be expected. The carrier initially applied physician and supplier specialty codes used by California Blue Cross. Investigation was made by the carrier to assign correct specialty codes. However, this was limited to referring to telephone directories.

Recommendation

A complete review of physician and supplier specialty codes must be made to insure proper assignment of codes. Contact with physicians and suppliers may be necessary to determine correct specialties. Specialty codes should be assigned in accordance with sections 6520.1 and 6520.2 of the Part B Intermediary Manual.

F. FINDING

Counts for the Monthly Workload Report (Form SSA-1565) are derived from computer listings, manual counts, or a combination of both. Personnel responsible for the monthly report entries provided the team with conflicting information as to which figures are used for reporting and how they are totaled for submittal to SSA. As a result, it is doubtful that the "Processed" data (lines f-i) on the report are accurate.

Recommendation

The carrier should review the many reports now being prepared to determine how the counts are arrived at by each unit, and the method used to prepare the monthly report for SSA. Consideration should be given to consolidation of internal reports so that more meaningful controls can be instituted to facilitate the prepa-

ration of the monthly report and provide accurate workload counts. Necessary action must be taken to revise present clerical procedures to adhere to sections 6540-6542 of the Part B Intermediary Manual.

G. FINDING

The count of claims received during the month (line d) is a manual count which is not accurate. Incoming claims are counted and grouped into packs of 50 for convenience of the subsequent inquiry function. A recount of some of the packs by members of the team revealed inaccuracies.

Recommendation

The carrier should investigate other means of obtaining receipt counts to insure greater accuracy. Consideration should be given to the assignment of sequential numbers by a hand stamp or mechanical device.

II. FINDING

The count for claims investigated (line q) is not accurate. The figure is computer-generated from a count of MEA's (Medical Expense Abstract), which are checked "investigated," rather than a count of actual claims investigated. Claim folders contained many claims which were investigated but were not identified on the MEA as requiring investigation and were, therefore, not included in the computer count.

Recommendation

The carrier should develop and implement a means of obtaining counts for investigated bills which would give accurate figures for workload reporting as specified in section 6542, page 174.3 of the Part B Intermediary Manual.

I. FINDING

Pending figures for the workload report are arrived at incorrectly. The total pending at the end of the month (line n) is obtained by adding receipts to opening pending and subtracting processed. Pending claims which were received during the month (line l) are obtained by subtracting the computer count of the prior month's pending claims from the total pending. The computer count of claims pending over 30 days is inaccurate since it is based on the Julian date of last computer entry rather than the actual date of claim receipt. (See Finding VI A.)

Recommendation

A review of both EDP and clerical functions must be made to assure correct reporting (section 6542 of the Part B Intermediary Manual). Controls should be established which will provide accurate counts of pending claims. The "original" date of receipt of a claim in the carrier's mailroom should be used in counting and reporting the number of claims pending over 30 days. It is recommended that the carrier take a physical inventory of claims inhouse for the October workload report.

J. FINDING

Clerical instructions provide for combining more than one assigned request for payment from an individual physician as one claim. Therefore, the computer count of payment records prepared (line o) is invalid and cannot be related to the number of claims received and processed.

Recommendation

To provide valid monthly workload figures, management must review clerical instructions and provide procedures and instructions for acceptable computer input.

K. FINDING

The carrier is understating the number of informal reviews received (line v), and cleared (line w), found for the claimant (line wl), and pending (line x). Correspondence expressing dissatisfaction with an initial determination is not considered a request for an informal review unless the claimant actually uses the words "informal review" in the correspondence. After replying to three or four complaints from the claimant, the carrier will inform the individual that he can request an informal review.

Recommendation

Any letter from a provider or beneficiary expressing dissatisfaction with the initial decision on the claim constitutes an informal review and should be reflected on the monthly report (section 6480-6482.2 and 6542, page 3-174.4 of the Part B Intermediary Manual).

L. FINDING

The carrier utilizes a night crew working from 5 p.m. to 10 p.m. to process continuous sample claims. The day crew receives and releases batches to and from SSA.

There appears to be a lack of communication between the two shifts which has resulted in incorrect processing and submittal of sample claims. The night shift is operating with obsolete procedures. The day shift is incorrectly resubmitting claims returned by SSA for correction in batches containing as many as 100 forms. The newly prepared transmittal which accompanies the batches of deletion returns is not noted as a deletion batch.

Recommendation

The possibility of handling all phases of the continuous sample operation by one shift should be considered. In the meantime, management should issue and discuss all current revisions and instructions with personnel responsible for handling continuous sample claims.

Claims corrected and resubmitted to SSA should be in batches of 25 or less forms. The old transmittals which list the HIC numbers and reasons for return should be attached to the new transmittal. Section 6615.2B of the Part B Intermediary Manual provides detailed instructions for resubmitting corrected deletions to SSA.

M. FINDING

Numeric codes and verbal descriptions used by the carrier for internal claims processing obliterate original entries on RFP's and bills. This makes it extremely difficult for SSA to process the claims.

Recommendation

Carrier codes and descriptions essential for inhouse processing should not obliterate original entries on claims. Extraneous information should be lined out prior to submittal to SSA. Rewriting the place of service (office for "0"; in-hospital for "I, H" etc.) is not necessary. Section 6510-6513, revision 170 of the Part B Intermediary Manual contains sample claim requirements which should be followed.

N. FINDING

A check mark (✓) correctly appears alongside the physician's charge if it is fully allowed. However, if the physician's charge is reduced, the charge is lined through and the allowed charge is entered, followed by a check mark (✓) and the carrier's internal two-digit disposition code.

Recommendation

In annotating reasonable charges, a check mark (✓) is required if the physician charges and the allowed charges are the same. If the original charge is reduced, only the allowed charge should be entered alongside the original physician charge. Neither a check mark (✓) nor other notations should follow the reduced charge. (Section 6513E of the Part B Intermediary Manual)

O. FINDING

Illegible copies of 5-percent sample bills have been submitted to Baltimore by the carrier.

Recommendation

Continuing emphasis should be placed in preparing and checking for legibility of copies. The carrier should ascertain why the material sent to Baltimore is not legible. If necessary, better photocopy equipment should be obtained.

Mr. SHARP. Now, I mentioned that at this meeting was one Mr. A. B. Halverson and I understand he is executive vice president of the company?

Mr. BIERSCHBACH. Senior executive vice president.

Mr. SHARP. I am sorry, senior executive vice president. Mr. Halverson, I understand, is also a very active member of the Health Insurance Association of America, is that true?

Mr. BIERSCHBACH. I don't know that he has been active.

Mr. SHARP. They will be before us. We will ask them that question.

Mr. FROST. Mr. Sharp, Mr. Halverson has had activities in the Health Insurance Association of America, but the reason we were giving a negative response to you is the "very active". I don't know that he has been particularly active. I am sure he has served on some committees, and is probably on a committee or two now, but certainly nothing that would constitute "very active".

Mr. SHARP. In your statement, you mention that, "Community health care planning must be improved to better distribute current and future health resources."

I take it that your company, Occidental, has been supporting the community health care planning agencies. The area-wide, as they call them, section 314-B agencies, across the country, particularly in Los Angeles, is that true?

Mr. FROST. Mr. Sharp, I am certainly no expert on these 314-B organizations. As I understand it, those organizations have been having some difficulties getting organized and getting their operations smoothed out and working well.

I am informed that, at the present time, they are inactive, reforming themselves to comply with Federal law so that they will be entitled to Federal grants. I am informed that those grants will be on a matching basis and that we would anticipate when they have complied with the Federal laws—we have not made a firm decision, of course, at this time—but we would anticipate being of assistance to them.

In other words, they show great promise but it is promise and not actual operations today.

Mr. SHARP. Mr. Frost, your company is a member of the Health Insurance Council, is it not, which is an arm of the Health Insurance Association of America?

Mr. FROST. That is right.

Mr. SHARP. And that council was formed a few years ago in order to assist the States, as well as the local areas, in setting up the area-wide, local comprehensive health plans, is that true?

Mr. FROST. I actually have no personal knowledge of that, Mr. Sharp.

Mr. SHARP. Do you, Mr. Bierschbach?

Mr. BIERSCHBACH. No, I do not.

Mr. SHARP. You have no personal knowledge of that? Are you speaking here today for your company?

Mr. BIERSCHBACH. I can only speak—to answer your direct question as to whether I have any knowledge, I can only say that I do not know what the activities of our company are.

Mr. SHARP. What are the activities of your company with respect to the Health Insurance Council? Would you have any knowledge there?

Mr. FROST. Our company has been active in the Health Insurance Council. We did not come here today anticipating questions on the Health Insurance Council and I am sorry, we are not prepared for them.

We came prepared to try to answer the questions in your letter and although I suppose this comes within that, we did not anticipate it.

JUNE 6, 1972.

TO: DEAN SHARP.

FROM: O. L. FROST, JR.

SUBJECT: 314(b) query.

Items that fall under 314(b) include:

Southern California Hospital Planning Association—\$5,250.

L. A. Health Planning Association—\$1,500.

Health Insurance Community Health Planning Fund—\$3,262.50.

HIAA (our portion of assessments allocated to HiCHAP demonstration programs): 1970—\$237, 1971—\$573.

O. L. FROST, JR.,

Vice President and Assistant to the Chairman of the Board,

Occidental Life Insurance Company of California.

Mr. SHARP. Well, I would just like to, then, refresh your recollection. We did have some conversations, I believe, on this point and perhaps, because you have been cooperative, we did ask for a lot of information and this could have been overlooked.

But I would like to introduce, Mr. Chairman, for the record, a document received from the HEW called "Comprehensive Health Plan, Los Angeles County, 1971" as well as a list of the board of directors, and listed under "consumer"—I should make it clear that before I do that, the law, establishing comprehensive health plans under 314-A and 314-B of the public health law, provides that there must be a majority of consumer representation on these planning agencies, and a study of the files of the HEW indicate that 15 States—the health insurance industry in these States, through the health insurance councils—have representatives on the 314-A State plans not in the capacity of providers.

As, for example, the Blue Cross representatives are listed in the capacity of providers. A number of areawide 314-B plans have health insurance company people listed as consumers and not as providers and also, in some instances, these people are sitting and operating on executive committees as the so-called swing vote between consumers and providers.

I would like to introduce for the record, these documents received from HEW, and particularly the Los Angeles document. I would call your attention to the fact that Mr. A. B. Halverson sits as a consumer—senior executive vice president of Occidental Life Insurance Co.—and perhaps you will furnish for the record a statement as to why a health insurance company representative is serving as a consumer and not in the category of provider.

Mr. BIRSCHBACH. We will be happy to supply that.

Mr. SHARP. We would appreciate that.

(Documents follow. Testimony resumes on p. 1080.)

SOURCES OF FUNDS, ESTIMATE, 1972

	Cash	In-kind	Nonmatching	Cash matching
United Way rent.....	\$12,000			\$12,000
LACMA.....	4,500	\$1,500		4,500
Voluntary health agencies.....	15,000			15,000
Fees-reviews (35 at \$2,000).....	70,000		\$35,000	35,000
State contract—facilities planning.....	75,000			75,000
Insurance companies.....	5,000			5,000
Los Angeles County.....		75,000		
Systems council.....		15,000		
Meetings contributions.....		1,500		
Individual contributions.....	1,000			1,000
Subtotal.....	182,500	96,000	35,000	147,500
SUMMARY				
Matchable cash.....	147,500			
Matchable in-kind.....	96,000			
Total.....	243,500			
Nonmatchable cash.....	35,000			
Total.....	278,500			
50 percent 1972 budget.....	210,728			
Overmatch 1972.....	(67,772)			

BOARD OF DIRECTORS—CONSUMERS

John Anderson.—Executive Director, Los Angeles Times Fund; Chairman, Los Angeles Times Summer Camp Fund, Los Angeles Times Boys' Club; Director, Alcoholism Council of Greater Los Angeles; Welfare Planning Council of Los Angeles; Western Harness Charity Foundation; EYOA; Recreation and Youth Services Planning Council; Los Angeles Child Guidance Clinic; Member, Health Facilities and Services Committee and Executive Committee.

Kay Bieby (Mrs. E. Rew).—Director, Welfare Planning Council; Executive Director, Volunteer Bureau of the Los Angeles Region; Volunteer Leader with United Way, Welfare Planning Council of the Los Angeles Region; U.S.O. Los Angeles Area; Mental Health Commission; Advisory Committee on Research and Planning for Aging; Member, Health Facilities and Services Committee.

Dorothy G. Bromage (Mrs. Kenneth).—Principal, E.S.E.A. Title I School in Claremont; President, Claremont Community Coordinating Council; Member, Phi Lambda Theta, N.E.A., California Association for Neurological Handicapped Children, National Association of Elementary School Principals' Association; Co-Chairman, Personal Health Services Committee.

Bernard Burton.—Burton Public Relations; Member, California Association of Bioanalysts; Exceptional Children's Foundation; Clergy Counseling Service for Problem Pregnancies; Monte Sano Hospital of California, Committee on Therapeutic Abortion; Member, Health Facilities and Services Committee.

Gloria Busman (Mrs. Robert B.).—Representative, Los Angeles and Orange County Organizing Committee AFL/CIO Office and Professional Workers #30; Board Member, Southern California Counseling Center, California Committee for Mental Health, Member, Mental Health Committee.

Wesley Anne Camburn (Mrs. C. B.).—Volunteer; Active in matters pertaining to pollution controls and safety standards; Member, Environmental Health Committee.

John Castro.—Social Service Assistant II Worker for State of California in East Los Angeles Area; Active in Youth Organizations, Health Involvements, Retarded Children, Economic Development, One of the Founders, East Los Angeles Health Task Force; Co-Chairman, Environmental Health Committee, Mexican-American.

Rev. George W. Cofield.—Baptist Minister; Leader in Community Affairs in South Central Los Angeles; Active in such organizations as Lions; President, Baptist Ministers Conference; President, Interdenominational Conferences, Afro-American.

Ernest E. Debs.—Member, Los Angeles County Board of Supervisors; Interest in all phases of community affairs and health; Member, Personal Health Services and Executive Committee.

Betty Debs (Mrs. Ernest E.).—President, Los Angeles Council of National Health Agencies: Active in community matters; Member, Health Facilities and Services Committee.

Charles J. Detoy.—Vice President, Coldwell, Banker and Company: Former Trustee, Good Samaritan Hospital; Layman, Episcopal Diocese of Los Angeles; Community Leader; Member, City of Los Angeles Health Advisory Council; Original President, Comprehensive Health Planning Association of Los Angeles County.

Juanita C. Dudley (Mrs. C. H.).—Assistant Western Regional Director, National Urban League; Past President, Charles Drew Women's Auxiliary, National Medical Association; Secretary, Area IV Regional Medical Programs, Heart, Cancer, Stroke; Executive Board, March of Dimes; Past Member, Los Angeles Health Council; Funding Board Member, Central City Mental Health Clinic; Member, APHA; Member, Personal Health Services and Executive Committee, Afro-American.

Simon Eisner.—President, Eisner and Associates: Planning Consultant to Cities and Counties; Active in community organizations such as United Way.

Fernando Escarccega.—Assistant Director, East Los Angeles Task Force (Resigned to return to college); Board Member, East Los Angeles Health Task Force; Co-Chairman, Health Manpower Committee; Member, Executive Committee.

Adelina Gregory (Mrs. Francis J.).—Mayor, Baldwin Park: Represents League of California Cities; President, COMP-LA; Active in East San Gabriel Valley Community Service Corps (Jobs for Youth); Board Member, United Way, A.I.D.; Residential Chairman, United Way; Associated In-Group Donors; Member, B.P. Intercultural Association, Friends of the Library; League of Women Voters; San Gabriel Area Health Services Council Exploration Group.

Patrick Groer.—Commercial Artist, Standard Packaging; Executive Board, California Association for the Retarded; Director, Executive Board, Los Angeles County Association for the Retarded; Executive Board, The Regional Center; Member, Los Angeles Packaging Group; Co-Chairman, Mental Retardation Committee; Member, Executive Committee.

A. B. Halverson.—Executive Vice President, Occidental Life Insurance Company of California; Director, California Hospital; Director, Lutheran Hospital Society; Chairman, California Health Insurance Council; Treasurer, Southern California Health Planning Council and COMP-LA.

Ellen Stern Harris.—Executive Secretary, Council for Planning and Conservation: Instrumental in passage of several bills by State legislature for community betterment; Member, Environmental Health Committee.

David D. Hurford.—Vice President, Sears Roebuck Foundation; Executive Board, Los Angeles Area Council of Boy Scouts, and Los Angeles Recreation and Youth Services Planning Council; Chairman, Advisory Board of California Museum Foundation; Past President, Los Angeles County Committee on Affairs of the Aging; Member, California State College Advisory Committee, Central City Development Committee, Public Relations Council USC, and Public Relations Advisory Committee UCLA; President, Board of Directors of Welfare Planning Council of Los Angeles Region; Member, Advisory Committee of California Hospital, and Southern California Industry-Education Council; Member, Environmental Health Committee.

Freita Shaw Johnson (Mrs. William V.).—President, American Cancer Society of Los Angeles; Chairman, Field Organizational Division National Board of ACS; Member, National Negro Musician Organization, Screen Actors Guild; Active in NAACP, Multipurpose Health, Watts Coordinating Council, LIVE, community affairs; Member, Mental Health, Executive and Nominating Committees Afro-American.

Joseph M. Kaplan.—Executive Vice President, Greater Los Angeles Chapter National Safety Council; Concerned with Alcoholism, Drug Abuse and related health problems.

Ira Kaufman.—President, Boston Stores; President, Centinela Valley Community Hospital; Trustee, Reiss-Davis Child Study Center; Active in community organizations and a leader in the business Community.

Father Frank Kelley.—Priest, Episcopal Church, Diocese of Los Angeles; Rector, St. Athanasius' Parish; Vicar, St. Francis' Episcopal Church; Chairman, Board of Zoning Appeals for City of Los Angeles; Member, Chamber of Commerce for Echo Park and Griffith Park; Member, Coordinating Councils of

Echo Park and Griffith Park; Columnist, Hick's Deal Publication; Commissioners' Council of Los Angeles; President, Monte Sano Hospital Foundation; Advisory Boards of South Central Mental Health District, East Valley Mental Health District, Gateways Hospital of Los Angeles; Chaplain for Monte Sano Hospital, Glendale Memorial Hospital, Barlow Sanatorium, Casa Verdugo Convalescent Hospital, Griffith Park Convalescent Hospital; Episcopal Chaplain for Queen of Angeles Hospital; Kaiser Hospital; Member, Health Facilities and Services Committee.

Celes King, III.—Life Member, N.A.A.C.P.; Board Director, Los Angeles Rumor Control and Information Center, Los Angeles City Human Relations Commission, and KPFK-FM Radio; Director, Los Angeles Brotherhood Crusader; Commissioner, Los Angeles School Black Education Commission. Afro-American.

Raymond E. Lee.—President, Roosevelt and Lee, Ltd., Advertising; Member, Boys' Club Foundation, Don Casco Technical Institute, United Jewish Welfare, University of Southern California, Western Harness Charity Foundation, Y.M.C.A., Claremont Men's College, Northrop Institute of Technology Department of Mental Hygiene; Vice President Board, Cedar-Sinai Medical Center and Gateways Hospital; Board Member and Past President, Menninger Foundation; Board of Trustees, Eisenhower Medical Center; Member Mental Health Committee.

Hon. Charles Litwin.—Judge, Municipal Court of Long Beach Judicial District; President, Long Beach Jewish Community Federation; Past President, Long Beach Jewish Family Service; Member, Mental Health Committee.

Rabbi Edgar F. Magnin.—Rabbi, Wilshire Boulevard Temple; Lecturer, Author, Civic Leader; Past Grand President, Independent Order of B'nai B'rith District No. 4; Member, Rotary Club of Los Angeles, and Mayor's Advisory Committee on Human Relations; Board of Directors, All-Year Club of Southern California; Board of Trustees, California College of Medicine; Board of Directors, Los Angeles Chapter National Red Cross; Board of Directors, Cancer Prevention Society, and Cedars-Sinai Medical Center.

Christy Marks (Mrs. Roberts).—Pediatric Volunteer Cedar Sinai Hospital; Active in community affairs; Attendance at Subcommittee on Alcoholism meetings; Member, Environmental Health Committee.

Alvin P. Mazzei.—President, Los Angeles County Federation of Labor AFL/CIO; Vice President, United Way; President, Southern Area Boys' Club, Economic-Youth Opportunity Agency; President of the Board, Los Angeles County Citizens Economy and Efficiency Commission; Board, Los Angeles Council Boy Scouts of America; Ex-Board, National Multiple Sclerosis Society; Public Health Foundation Committee; California Committee for Mental Health; United Cerebral Palsy Association of Los Angeles; California Association for Health and Welfare; Mental Health Development Commission; Member, Mental Health Committee.

Francis X. McNamara, Jr.—General Manager, United Way, Inc; Member, Mental Health Committee.

Versia Metcalf (Mrs. Freddie).—Representative, Conservation and Consumers United Auto Workers; Active in community affairs; Member, Environmental Health Committee.

Leanore Minghini (Mrs. Floyd).—Community Advisor, Valley College in Van Nuys; Chairman, Drug Abuse Committee of San Fernando Valley Health Planning Group; Chairman, Van Nuys Free Clinic; Commissioner, Los Angeles County Delinquency and Crime Commission; Active in Youth Clinics, Free Clinics and Drug Abuse Clinics; Member, Health Facilities and Services Committee.

Muriel Morse (Mrs. Barnard).—General Manager, City of Los Angeles Personnel Department; Immediate Past President, Soroptimist Federation of the Americas; Active in affairs of the community, and administers occupational health plan for City of Los Angeles.

Thomas P. Pike.—Vice Chairman of the Board, Fluor Corporation; Member, United Way, Alcoholism Council of Greater Los Angeles; President, Recovery House for Women, Republican Party, Loyola University Independent Colleges of Southern California, and KCET Channel 28 Community TV; Member, Personal Health Committee, Alcoholism Subcommittee, and Fund Raising Committee.

John Pirley.—Executive Director, Welfare Planning Council; Active in Health and Welfare Planning, Citizen Involvement, Pluralistic Planning, Application of Systems Approach to Community Planning; Member, Mental Health Committee and Executive Committee.

Mary Roberts Ripley (Mrs. Alexander B.).—Volunteer, Los Angeles Region Welfare Planning Council Mental Health Development Commission; Past President, Association of Volunteer Bureaus of America; Commissioner, State Social Welfare Board of State of California; Vice President, Child Welfare League of America and Welfare Planning Council of Los Angeles Region; Chairman, Advisory Committee for Plays for Living of Southern California; Member, Mental Health Development Commission; Board, President Nixon's National Center for Voluntary Action; Volunteer Board, Los Angeles County Heart Association, Resthaven Psychiatric Hospital, United Way, Children's Home Society of California, Alcoholism Council of Greater Los Angeles, National Assembly for Social Policy and Development, and Institute of International Education; Award Recipient, Los Angeles Times Woman of the Year, United Way Gold Key, Los Angeles County Heart Association Distinguished Achievement, California Heart Association Meritorious Service Award, American Heart Association Award of Merit; Member, Mental Health Committee and Nominating Committee.

Jannie Ross.—Volunteer Worker; Board of Directors, Southern Central Multipurpose Health Services Center in Watts District; Active in P.T.A., church work, lodges and special clubs; Member, Mental Retardation Committee, Afro-American.

Shirley Ross.—(Mrs. John A., Jr.).—Adoption Worker with Natural Parents, Los Angeles County Department of Adoptions; Child Welfare Worker; Compton Union High School District, Adult School Instructor, Parent Education; Program Chairman, Southeast Area Welfare Planning Council; Co-Chairman, Southeast Area Agency Executive Advisory Committee; Instrumental in continuing education being offered to pregnant teenagers in Compton Union High School District; Member, Health Manpower Committee, Afro-American.

Patricia Rostker (Mrs. Skipper).—Representative, League of Women Voters; Member, Community Planning Council of Pasadena Area; Member, Pasadena Commission on Human Needs and Opportunity; Member, Advisory Board, Neuropsychiatric Institute UCLA; Co-Chairman, Mental Health Committee; Member, Executive Committee.

Vera Saucedo (Mrs. Joseph).—Consultant/Advisor, Mexican-American Community on Health Issues for East Los Angeles Health Task Force; Board of Directors, Los Angeles Tuberculosis and Respiratory Disease Association; East Los Angeles Child and Youth Clinic; Advisory Committee, Compensatory Education, Title I, Los Angeles Board of Education; Health Chairman, Atlantic Council Parent-Teachers Association; Member Liaison Committee, Los Angeles County Mental Health Board; Advisory Committee/Board Member, Los Angeles County Skill Center in Monterey Park; Member, Los Angeles County University of South California Medical Center (Chicano); Founder, East Los Angeles Health Task Force; Member, Executive, Personal Health Services, Mental Health Committees; Mexican-American.

Bert Schierson.—Certified Public Accountant; Partner, Westheimer, Fine and Berger; Board of Directors, California Society of CPA's, Former Troop Chairman, Boy Scouts of America; Member, Personal Health Services Committee; Chairman, Subcommittee for Emergency Care.

Arnold J. Stone, Esq.—Attorney; Partner, Wainer and Stone; President, Board of Directors of Los Angeles Psychiatric Service; Legal Counsel, Association of California Branch of American Psychiatric Association, Southern California Psychiatric Society, Southern California Psychoanalytic Institute; Active in Mental Health Legislation; Member, Mental Health Committee.

Gertrude Stone.—Representative, Los Angeles County Federation of Labor, Community Services Department of United Way, AFL-CIO; Member, Home-making Council; Member, Personal Health and Services Committee.

Lucille Stout (Mrs. Joseph).—Former Teacher; Member Los Angeles County Humane Relation Commission, Pasadena Salvation Army-Women's Auxiliary; Former Chairman and Member, Los Angeles County Hospital Advisory Commission, Los Angeles County Youth Commission; Co-ordinator, Narcotics and State (C.M.A.) Symposiums; Women's Auxiliary to Los Angeles County Medical Association; Former President, Associates of Pasadena Foundation Medical Research Foundation on Cancer; Chairman, San Gabriel Valley March of Dimes and Heart Fund Drives; Co-Chairman, Health Facilities and Services Committee; Member, Executive Committee.

Dolores Tomlin (Mrs. Wilford).—Consultant, U.S. Department of Health, Education and Welfare Social Rehabilitation Service; Executive Board, Federation Coordinating Councils; Chairman, Mental Health Committee of Los Angeles

County; Active in Health Planning (Long Range), Manpower Development; Afro-American.

Elinor Walters (Mrs. J. S.).—Former School Teacher; Active in PTA, Los Angeles Tenth District C.C.P.T., Member, Executive Board, Los Angeles Tenth District; Chairman, Los Angeles Tenth District Community and Environmental Health; Member, Environmental Health Committee.

Kenneth S. Wing, Jr.—Architect; Active in Kiwanis, Boy Scouts, Community Volunteer Organizations; Advisor, Cerritos Junior College; Member, Health Facilities and Services and Executive Committee.

OCCIDENTAL LIFE OF CALIFORNIA,

June 20, 1972.

From: Executive Department.

To: Mr. Raymond A. Bierschbach, Executive Vice President and Actuary.

Subject: Hart Committee.

In March, 1971, the President of the Comprehensive Health Planning Association asked me to serve on the Planning Committee. He interrogated me on the activities of my work.

As you know, at that time I was in charge of all operations of the Company and not exclusively working on group insurance, as was the condition in years gone by, having some 2,200 people under my supervision involving all activities in the Company.

Since more than 50%, as it so happens, probably 85-95% of my time was spent in general administration and not in the health insurance field.

I was assured by the members of the Planning Council that they could list me as a consumer. I reiterated that if there was any doubt to put me down as a provider. I held the position of Treasurer from April 15, 1971 to November 30, 1971, at which time I resigned.

At no time did I vote on an issue where there could be a conflict of interest, and with the assurance on the part of the President, other Directors and Legal Counsel, there was no concern on my part in serving on the Comprehensive Health Planning Council.

I think the gentleman who made inquiry to you before the Committee did not understand the nature of my work or of my interest in making planning work.

I believe the above should answer the inquiry at the time of your interrogation before that Committee.

A. B. HALVERSON,

Senior Executive Vice President.

Mr. SHARP. I would like to move on to a few other points. We notice, Mr. Bierschbach, that Occidental has a conversion policy. That is, if I own a group health policy and I have to leave the company for any reason, I have a right or a privilege to convert that policy into an individual policy, is that correct?

Mr. BIERSCHBACH. That is correct.

Mr. SHARP. If an employee is insured under one of your major medical plans, sponsored by an employer, and loses his job and is unable to find employment with another employer who offers a similar health insurance plan, he may wish to take advantage of, like I say, this conversion "privilege." May he retain the same policy?

Mr. BIERSCHBACH. He will get a conversion policy.

Mr. SHARP. Your answer is, "No, he may not retain the same policy?"

Mr. BIERSCHBACH. The policy would not be—

Mr. SHARP. Would it be a policy offering lesser benefits than the group policy?

Mr. BIERSCHBACH. That would depend on what the group policy offered.

Mr. SHARP. Let us assume, then, that it is a group policy offering a full range of inpatient and outpatient hospital care, such as one of your major group plans that you have supplied to us. Suppose that the person were covered on the basis of major medical policy conversion; would the conversion policy also provide dental care?

Mr. BIRSCHBACH. I do not believe that the conversion policy provides dental care.

Mr. SHARP. What about convalescent facility benefits?

Mr. BIRSCHBACH. I am not sure on that.

Mr. SHARP. Perhaps you could supply that for the record. How about outpatient benefits?

Mr. BIRSCHBACH. I am not sure of the details of the conversion policy. I believe there is a choice of several.

Mr. SHARP. You have submitted to the subcommittee data concerning this point and apparently, from the material that you have submitted, your conversion policies do not cover out patients, do not cover extended care facilities, and do not cover dental care.

Perhaps you will outline to us a list of the things that this "privilege" does grant to the consumer when he converts to an individual policy?

Mr. BIRSCHBACH. I will be happy to send you the details on the conversion policies. I believe the request for that information came last week while I was out of town and I did not get a chance to review it.

(Documents follow. Testimony resumes on p. 1104.)

INFORMATION REGARDING YOUR GROUP MEDICAL EXPENSE CONVERSION PRIVILEGE

1. Read the next two pages describing the benefits available to you.
2. Read the last page to determine the plan for which you are eligible and the premium for that plan.
3. Complete and mail the lower portion of the addressed postcard, the upper portion of which has been completed by the Group Policyholder.

GENERAL INFORMATION

If the group policy under which you are insured continues in force when your group insurance terminates, you may purchase a special individual medical expense policy without a medical examination. This also applies to your dependent children whose insurance under the group policy ceases because of age. To take advantage of this conversion privilege, you must apply within 31 days from the termination date of your group insurance. You must also pay the required premium within the same 31 days or as otherwise specified by the Company.

Your dependents may be covered if they were previously covered under your group policy. But if any dependent is to be converted under your plan, all dependents (except children age 19 and over) must be included. If your dependent spouse is eligible for Medicare, coverage under the converted policy is not available to your spouse. If you are now eligible for Medicare, but your dependent spouse is not, you may apply for a converted policy for your spouse and eligible children, if any: Medicare means the hospital and medical benefits provided under U.S. Public Law 89-97, "Health Insurance for the Aged Act" including any future amendments.

The effective date of the policy is the day following termination of your group insurance. The policy is initially effective for the period for which the first premium is paid.

Renewability: The policy is guaranteed renewable to the eligible age for Medicare; however, the Company reserves the right to change the rates applicable to premiums becoming due under the policy but only on a class basis.

Since the policy is an individual policy, you will find that THE BENEFITS IT CONTAINS WILL PROBABLY DIFFER FROM THOSE OF YOUR PREVIOUS GROUP COVERAGE.

EXPENSES NOT COVERED

In order to keep your premiums lower, the following are not covered:

Any injury or sickness covered by any Workmens' Compensation or Occupational Disease Law.

War or any act of war or while in military service of any country at war.

Treatment or confinement in any facility contracted for or operated by the Government of the United States for the treatment of members or ex-members of the armed forces.

Pregnancy, childbirth, miscarriage or abortion.

If during a single surgical session two or more operations are performed either in the same operative field or through the same incision, only the largest amount applicable to any of the operations shall be the surgery limit allowable.

Flight in a non-civilian aircraft or flight except as a fare-paying passenger on a civilian aircraft.

Cosmetic and Dental Surgery, except as required to correct a condition resulting from injury occurring while insured.

THIS IS A GENERAL DESCRIPTION OF THE BENEFITS AVAILABLE. CONSULT THE POLICY FOR EXACT DETAILS OF ITS TERMS AND CONDITIONS

DESCRIPTION OF BENEFITS

Covered expenses are those described in Parts 1-5 and which are incurred upon recommendation of a doctor as necessary to the treatment of injury or sickness. The maximum amount payable for each benefit is based on the plan for which you are eligible.*

Part 1. Daily Hospital Expenses—are the daily charges by a hospital for room, board, and general nursing care. The maximums per day and per disability are shown in the Table of Benefits.

Part 2. Miscellaneous Hospital Expenses—are the charges by a hospital for services other than room, board, and general nursing care. These include use of the operating room, anesthetics, x-ray examinations, administration of anesthetics, laboratory tests, surgical dressings and medicines. The maximum benefit is shown in the Table of Benefits.

Part 3. Surgical Expense—is the charge by a doctor for a surgical operation and any post-operative visits. The maximum benefit for (1) surgical procedures is shown in the Schedule of Maximums for Surgical Operations in your conversion policy, and (2) all surgery during any one disability is between \$450 and \$675 depending on the plan.

Part 4. Doctor's In-Hospital Visits Expenses—is the charge made by the attending doctor for in-hospital visits other than post-operative visits. (See Part 3). The maximum per day and per disability are shown in the Table of Benefits.

Part 5. Ambulance Expense—is the charge for professional ambulance transportation to or from the hospital. The maximum for each period of hospital confinement is the same as the Daily Hospital Benefit.

TABLE OF BENEFITS

	Plan I	Plan II	Plan III	Plan IV
DAILY HOSPITAL EXPENSE BENEFIT				
Maximum per day of confinement.....	\$14	\$20	\$26	\$32
Maximum per disability.....	434	620	806	992
MISCELLANEOUS HOSPITAL EXPENSE BENEFIT				
Maximum per disability if total period of hospital confinement is:				
1 day.....	70	100	130	160
2 days.....	84	120	156	192
3 days.....	98	140	182	224
4 days.....	112	160	208	256
5 days.....	126	180	234	288
6 days.....	140	200	260	320
7 days.....	154	220	286	352
8 days.....	168	240	312	384
9 days.....	182	260	338	416
10 days.....	196	280	364	448
11 days or more.....	210	300	390	480
DOCTOR'S IN-HOSPITAL VISITS EXPENSE BENEFIT				
Benefit for each day professional visit is made.....	4	5	6	0
Maximum per disability.....	124	155	186	217

HOW TO SELECT THE CONVERSION PLAN YOU ARE ELIGIBLE FOR AND CALCULATE THE PREMIUM

CONVERSION PLANS

There are four plans shown. However, you are eligible for only one. Select your plan from the table below.

		Your conversion plan is:
	Plan number	Daily hospital expense benefit
If the amount of daily hospital expense benefit under your group plan was:		
Less than \$20.....	I	\$14
\$20 to \$25.99.....	II	20
\$26 to \$31.99.....	III	26
\$32 and over.....	IV	32
Full cost ward or semiprivate.....	IV	32
All major medical plans.....	IV	32

Note: The converted policy does not contain major medical benefits.

Premiums for Converted Policies (the Company reserves the right to change rates) Premiums may be paid quarterly, semi-annually or annually. Quarterly premiums are the sum of the applicable premiums shown below plus \$.50. Semi-annual premiums are twice the applicable premiums shown below plus \$.50. Annual premiums are four times those shown below. Renewal premiums do not increase by reason of increase in age.

	Plan			
	I	II	III	IV
Male (employee or husband): ¹				
Age to 39.....	\$24.00	\$30.00	\$34.00	\$37.50
40 to 49.....	31.00	42.00	47.50	55.50
50 to 59.....	39.50	49.50	57.00	67.00
60 to 64.....	43.50	53.50	63.00	73.00
Female (employee or wife): ¹				
Age to 39.....	37.50	45.50	53.50	61.00
40 to 49.....	39.50	47.50	55.50	63.00
50 to 59.....	42.00	49.50	57.00	67.00
60 to 64.....	43.50	53.50	63.00	73.00
Children (1 or more).....	² 32.00	² 37.50	² 43.50	² 49.50

¹ The age last birthday is to be used.

² Add \$7.00 if parents' group insurance not converted.

Examples:

1. A man age 35 wishes to insure himself, his wife age 30, and his children. The room and board daily benefit under his group plan is \$18.00. The quarterly premium for Plan I (see above) would be \$24.00 plus \$37.50 plus \$32.00 plus \$.50, or \$94.00. The semi-annual premium would be \$48.00 plus \$75.00 plus \$64.00 plus \$.50, or \$187.50. The annual premium would be \$96.00 plus \$150.00 plus \$128.00, or \$374.00.
2. A woman age 51 wishes to insure herself and her children. The room and board daily benefit under her group plan is \$31.00. The quarterly premium for Plan III (see above) would be \$57.00 plus \$43.50 plus \$.50, or \$101.00. The semi-annual premium would be \$114.00 plus \$87.00 plus \$.50, or \$201.50. The annual premium would be \$228.00 plus \$174.00, or \$402.00.
Man and wife, 50, and kids equal \$734.

TO BE COMPLETED BY POLICYHOLDER

please print or type full name with ceased to be eligible for coverage under group policy number date

due to state reason for cessation of coverage

signed by

title

date signed

TO BE COMPLETED BY APPLICANT

I WANT AN APPLICATION FOR MEDICAL COVERAGE. I UNDERSTAND THAT (1) I MAY ONLY CONVERT FOR THOSE INSURED UNDER THE GROUP PLAN, (2) IF I APPLY FOR DEPENDENT COVERAGE I MUST INCLUDE ALL DEPENDENTS PREVIOUSLY COVERED UNDER THE GROUP PLAN (CHILDREN MUST BE UNDER 19), AND (3) I MAY NOT CONVERT THE COVERAGE OF ANY PERSON OVER AGE 65 OR ELIGIBLE FOR MEDICARE.

I UNDERSTAND THAT I MUST MAIL THIS COMPLETED CARD WITHIN 31 DAYS FROM THE DATE I CEASE TO BE ELIGIBLE UNDER THE GROUP PLAN OR I WILL LOSE MY CONVERSION PRIVILEGE.

☐ I WANT TO INSURE MY ELIGIBLE DEPENDENTS:

- ☐ SPOUSE ONLY
☐ SPOUSE & CHILDREN
☐ CHILDREN ONLY

spouse's date of birth

home address

signed

date signed

city—state—zip code

☐ Male
☐ Female
 date of birth

FIRST CLASS
Permit No.
3542
Los Angeles,
Calif.

BUSINESS REPLY MAIL

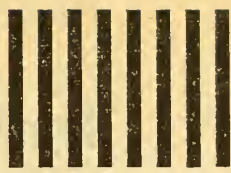
No postage stamp necessary if mailed in the United States

Postage will be paid by

Occidental Life of California

*Box 2101 Terminal Annex
Los Angeles, California 90051*

Group Accounts Service Department



CONVERTER POLICY FORM

APPENDIX B

Occidental Life

Insurance Company of California

HOME OFFICE Los Angeles

A Stock Company

Occidental Life Insurance Company of California will pay the amount of covered expenses for each injury or each sickness of a covered member, subject to the provisions, definitions, exceptions and reductions in this policy.

No benefits shall be payable under this policy for any expenses payable by the Medicare program or by any state or other governmental plan or law providing a hospital and medical expense program other than a program for governmental employees or their dependents. Expenses covered by a Workmen's Compensation or Occupational Disease Law are not covered by this policy. Treatment in any facility contracted or operated by the United States Government for members or former members of the armed forces is not covered by this policy.

This policy is issued under the conversion provision of Group Policy No. _____. No payment shall be made under this policy for any medical, surgical, ambulance or hospital expenses for which the Company is required to make payment under the terminated group coverage.

This policy is issued in consideration of the application, a copy of which is attached to and made a part of this policy, and the payment of the initial premium.

POLICY DATA

The Insured:	Policy No.		
Date of Issue:	Initial Premium: \$	Initial Term:	Months.
Covered Expenses and Maximum Amounts Payable			
Daily Hospital Expense	Maximum per day: \$ _____ Maximum number of days for each injury or sickness: _____		
Miscellaneous Hospital Expenses	Maximum as determined by Table for Maximum Miscellaneous Hospital Expense on page 3.		
Surgical Expense Surgical Factor \$ _____	Maximum for each operation: The amount shown in the Schedule of Surgical Operations for the operation performed multiplied by the Surgical Factor. Maximum for each injury or sickness: 150 times the Surgical Factor.		
Doctor's In-Hospital Visits Expense	Maximum per day: \$ _____ Maximum for all visits for each injury or sickness: \$ _____		
Ambulance Expense	Maximum for each hospital confinement: \$ _____		

GUARANTEED RENEWABLE TO AGE 65 BUT NOT BEYOND ELIGIBILITY FOR MEDICARE PREMIUM RATE SUBJECT TO CHANGE

The Insured has the right to continue this policy in force by payment of the required premium as it becomes due or within the grace period. The premium shall be due on the first day of the term immediately following the expiring term for which a premium has been paid. Each term shall begin and end at 12:01 A.M. Standard Time at the residence of the Insured. If any premium remains unpaid after the grace period, this policy shall terminate.

On each policy anniversary, the Company has the right to change the premium for this policy. However, a change in premium shall not be made unless the changed premium rates apply to all policies of the same rating class, policy duration and policy form as this policy. Premiums shall be based on the original insuring age for this policy with respect to each covered member.

The premium for any term during which a covered member attains age 65 or becomes eligible for Medicare benefits shall include only the pro-rata portion of the premium for such covered member for the number of days from the premium due date to the date such covered member attains age 65 or becomes eligible for Medicare benefits.

Upon termination of coverage of any covered member, the premium for this policy shall be reduced by the portion of the premium payable for such covered member.

While this policy is in force, the Company shall not have the right to increase the rating class of this policy because of a change in health or occupation of a covered member and shall not have the right to add any restrictive rider to this policy.

HOSPITAL AND MEDICAL EXPENSE POLICY

Guaranteed Renewable to Age 65 but Not Beyond Eligibility for Medicare
Premium Rate Subject to Change

5-970 58-166

POLICY GC-22

Page 1



A Member of
Transamerica Corporation

DEFINITIONS

As used in this policy:

"Injury" means an accidental injury for which covered expenses are incurred after the date of issue and while this policy is in force. "Each injury" means all injuries to a covered member as a result of one accident, including all related conditions. If no covered expenses are incurred for an injury for any period of 6 consecutive months, any additional covered expenses incurred for that injury shall be considered as incurred for a new injury for the purpose of determining the limits of coverage, but only if such additional covered expenses commence while this policy is in force; otherwise, no benefits shall be payable under this policy for such additional covered expenses.

"Sickness" means a sickness for which covered expenses are incurred after the date of issue and while this policy is in force. "Each sickness" means a sickness and all recurrences from the same cause. If no covered expenses are incurred for a sickness for any period of 6 consecutive months, any additional covered expenses incurred for that sickness shall be considered as

incurred for a new sickness for the purpose of determining the limits of coverage, but only if such additional covered expenses commence while this policy is in force; otherwise, no benefits shall be payable under this policy for such additional covered expenses.

"Doctor" means a person who is licensed to practice medicine and surgery as a Doctor of Medicine or as a Doctor of Osteopathy. To the extent that this policy covers their legally authorized services, Doctor shall include a person licensed to practice as a Dentist, Podiatrist or Optometrist. Doctor shall not include any person who is related by blood or marriage to any covered member.

"Hospital" means only an institution which lawfully provides medical and surgical care for injury and sickness, with at least one doctor in attendance at all times and with continuous 24 hour nursing service, and which is not operated primarily for the care of alcoholics or narcotic addicts, or primarily as a rest home or a home for the aged.

"Medicare" means Public Law 89-97, Health Insurance for the Aged Act, as amended.

INSURED AND COVERED MEMBERS

If the Insured named in the policy dies while this policy is in force, the spouse of the Insured, if then a covered member, shall become the Insured for this policy. If the spouse of the Insured named in the policy data has died before such Insured or is not a covered member at the death of such Insured, this policy shall terminate at the end of the term during which the death of such Insured occurs.

The covered members under this policy are the Insured and the members of the Insured's family who are named for dependent

coverage in the application for this policy. The persons eligible to be covered members are (1) the Insured, (2) the spouse of the Insured, and (3) the dependent unmarried children of the Insured or of his spouse, who are over age 14 days and under age 19 years. Any person eligible to be a covered member may become a covered member upon written application by the Insured, evidence of insurability of such person satisfactory to the Company, and payment of the required premium based upon the then attained age nearest birthday of such person. A dependent unmarried child after becoming a covered member shall continue as a covered member to age 22 years, subject to the termination of covered member status.

TERMINATION OF COVERED MEMBER STATUS

Insured—The Insured shall automatically cease to be a covered member under this policy on his 65th birthday or upon becoming eligible for benefits under Medicare.

Spouse of the Insured—The spouse of the Insured shall automatically cease to be a covered member under this policy (1) on the 65th birthday of the spouse or upon becoming eligible for benefits under Medicare; or (2) the end of the term during which the spouse is divorced or legally separated from the Insured.

Dependent Child—A dependent child shall automatically cease to be a covered member under this policy at the end of the term during which (1) such child attained age 22 years; or (2) such child marries; or (3) the Insured ceases to be legally responsible for the care and support of such child.

If the Company accepts the premium for a covered member after such covered member attains age 65 or becomes eligible for Medicare benefits, the coverage provided by this policy for such covered member shall continue in force until the end of the term for which the premium has been accepted.

If the Company accepts the premium for the spouse of the Insured after receiving notice of the divorce or legal separation of the spouse from the Insured, the coverage provided by this policy for the spouse of the Insured shall continue in force until the end of the term for which the premium has been accepted. If the Company accepts the premium for a child after such child has attained age 22, or after receiving notice that such child has married or is no longer a legal dependent of the Insured, the coverage provided by this policy for such child shall continue in force until the end of the term for which premiums have been accepted.

COVERED EXPENSES

The covered expenses of a covered member shall be the expenses which are described in Parts 1, 2, 3, 4 and 5, and which are incurred upon recommendation of a doctor as necessary to the treatment of injury or sickness of that covered member. The covered expense for each injury or sickness shall be the expense actually incurred but not more than the maximum provided in this policy for such expense.

Part 1. DAILY HOSPITAL EXPENSE .

The daily hospital expense is the charge by a hospital for room, board and general nursing care. The maximum amount of daily hospital expense payable for each day shall be as shown in the policy data. The maximum number of days the daily hospital expense shall be payable for each injury or sickness shall be as shown in the policy data.

Part 2. MISCELLANEOUS HOSPITAL EXPENSES.

The miscellaneous hospital expenses are the charges by a hospital during confinement of the covered member for services other than room, board and general nursing care. Miscellaneous hospital expenses shall include the charges for:

- (1) Use of the operating room
- (2) Anesthetics
- (3) Administration of anesthetics
- (4) X-ray examinations
- (5) Laboratory tests
- (6) Surgical dressings
- (7) Medicines

The maximum amount payable for miscellaneous hospital expenses shall be the amount determined by the following table for the total number of days the covered member is confined in the hospital for the injury or sickness.

Table for Maximum Miscellaneous Hospital Expenses

Days Confined in Hospital	Amount for each \$1.00 of the Maximum per Day of Daily Hospital Expense
1.....	\$ 5.00
2.....	6.00
3.....	7.00
4.....	8.00
5.....	9.00
6.....	10.00
7.....	11.00
8.....	12.00
9.....	13.00
10.....	14.00
11 or more.....	15.00

Part 3. SURGICAL EXPENSE.

The surgical expense is the charge by a doctor for a surgical operation and any post operative visits. The maximum for the surgical expense with respect to each injury or each sickness and for each surgical operation shall be as shown in the policy data.

Part 4. DOCTOR'S IN-HOSPITAL VISITS EXPENSE.

The doctor's in-hospital visits expense is the charge by the attending doctor for professional in-hospital visits other than post operative visits. Post operative visits by the doctor performing the surgery, or by his designate are not covered expenses under this part (See Part 3). The maximum per day for doctor's in-hospital visits and the maximum for all such visits for each injury or sickness shall be as shown in the policy data.

Part 5. AMBULANCE EXPENSE.

The ambulance expense is the charge for professional ambulance transportation of the covered member to or from the hospital. The maximum for the ambulance expense for each period of hospital confinement shall be as shown in the policy data.

EXCEPTIONS AND REDUCTIONS

This policy does not cover any expenses caused or contributed to by:

1. Any intentionally self-inflicted injury, or any attempt at suicide, sane or insane.
2. Any injury which occurs because of travel or flight in an aircraft:
 - a. While the covered member is a pilot or member of the crew; or
 - b. While such aircraft is being operated
 - (1) For training, practice, experimental or test purposes; or
 - (2) For any utility purpose other than transportation; or
 - (3) Under the direction of any military or naval authority.

No benefits shall be payable under this policy for any expenses payable by the Medicare program or by any state or other governmental plan or law providing a hospital and medical expense program, other than a program for governmental employees or their dependents. The portion of this exception relating to benefits payable by Medicare shall not apply during any period for which the Company accepts the premium after the covered member becomes eligible for Medicare benefits.

No payment shall be made under this policy for any medical, surgical, ambulance or hospital expenses for which the Company is required to make payment under the terminated group coverage.

3. Cosmetic or dental surgery, except as required to correct a condition resulting from injury.
4. War, declared or undeclared, or any act of war.
5. Any injury or sickness covered by any Workmen's Compensation or Occupational Disease Law.
6. Treatment or confinement in any facility contracted or operated by the United States Government for the treatment of members or former members of the armed forces.
7. Pregnancy, childbirth, miscarriage or abortion.
8. Any injury or sickness suffered while in the military or naval service of any country at war, declared or undeclared. The pro rata unearned premium, if any, for any period during which any covered member is in such military or naval service will be returned upon notice of such service.

SCHEDULE OF SURGICAL OPERATIONS

FOR DETERMINING MAXIMUM SURGICAL EXPENSE

The amounts shown in this schedule are multiplied by the surgical factor shown in the policy data in determining the maximum for the surgical operation.

If the surgical operation performed is not shown in this schedule, an operation of equivalent gravity and severity shown in this schedule and similar to the operation performed shall be used by the Company to determine the maximum.

If multiple operations are performed at the same time in the same operative field, the maximum for all the operations combined shall be the largest of the maximums for the operations separately.

If multiple operations are performed at the same time but in different operating fields and through different incisions, the maximum for all the operations combined shall be the sum of the maximums for the operations separately. However, if bilateral procedures are performed at the same time in different operating fields, the maximum for the operations combined shall be 150% of the maximum for the single procedure. In either case, the maximum for multiple operations or bilateral procedures shall not exceed the maximum surgical expense for each injury or sickness as shown in the policy data.

INTEGUMENTARY SYSTEM

Code	AMOUNT
0101 Incision and drainage of infected or non-infected sebaceous cysts (up to 5).....	2
0102 Incision and drainage of furuncle.....	2
0108 Incision and drainage of carbuncle, hidradenitis suppurativa, and other cutaneous or subcutaneous abscesses, simple.....	2
0115 Drainage of pilonidal cyst.....	2
0140 Drainage of hematoma, simple.....	2
Excision (including simple repair) of lesion of skin, subcutaneous tissue or mucous membrane: Benign: [50% for each additional up to 3 lesions]	
0176 Lesion diameter ¼ to ½ inch.....	5
Malignant: Trunk, arms or legs	
0189 Lesion diameter ¼ to ½ inch.....	8
Face, scalp, ears, neck, hands, feet or genitalia	
0192 Lesion diameter ¼ to ½ inch.....	15
Eyelids, lips, mucous membrane	
0195 Lesion diameter ¼ to ½ inch.....	20
0238 Excision of pilonidal cyst or sinus.....	30
0251 Wounds, small [suture of recent small wounds requiring closure], up to 2 ½ inches.....	4

Grafts

0288 Skin grafts, pinch or split skin, one square inch or less, e.g., digit or small ulcer.....	5
0289 split skin 1 to 32 square inches (except 0288)	25
0291 each additional 32 square inches or part thereof at same procedure.....	10
0295 free full thickness, up to 3 square inches, including direct closure of donor site.....	20
0296 each additional 3 square inches or part thereof at same procedure.....	10
0308 direct flap transfer or tube pedicle formation, delay, intermediate transfer, or sectioning or pedicle of tube or flap graft.....	20
0310 delay, intermediate transfer, or sectioning or pedicle of tube or flap graft.....	15
0319 Composite graft (full thickness of external ear or nasal ala).....	25
0325 Dermo-fat-fascia-graft.....	45

Burns—(Does not include skin grafts.)

0351 Initial treatment, first degree, where no more than local treatment necessary.....	2
0352 Dressings, initial or subsequent under anesthesia, small.....	4
0353 under anesthesia, large or with major debridement, per hour.....	10
0354 without anesthesia, small, office or hospital.....	2
0355 without anesthesia, medium (whole face or whole extremity, etc.).....	3
0356 without anesthesia, large (more than one extremity, etc.).....	4

Breast Surgery

0444 Excision of cyst, fibro-adenoma or other benign tumor, aberrant breast tissue, duct lesion (including gynecomastia) or nipple lesion (including any other partial mastectomy), mole or female, unilateral.....	15
0457 Complete (simple) mastectomy.....	30
0470 Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes.....	70

MUSCULOSKELETAL SYSTEM

Code	AMOUNT
Bone Surgery	
0557 Carpectomy.....	30
0561 Patellectomy or hemi-patellectomy.....	50
0563 Metatarsiectomy.....	25
0618 Bone graft: radius, ulna.....	65
0635 Spinal fusion, 2 or more segments.....	100
0650 Pectus excavatum (major) plastic repair.....	90
0654 Epiphyseal-diaphyseal fusion; epiphyseal arrest; epiphyseodesis; stoping, femur.....	55

Fractures

FACIAL BONES

0686 Nasal, uncomplicated, closed reduction.....	5
0699 Maxilla, closed reduction, with wiring of teeth.....	30
0701 open reduction with wiring of teeth and/or local fixation.....	50

SPINE AND TRUNK

0722 Vertebral body, requiring reduction.....	30
0741 Clavicle, simple, closed reduction.....	15
0742 compound, including uncomplicated soft tissue closure.....	20
0743 simple or compound, open reduction.....	40

UPPER EXTREMITY

0786 Humerus, shaft, simple or compound, open reduction.....	45
0797 Elbow, simple or compound, open reduction.....	55
0799 Radius, head, closed reduction.....	15
0800 compound with uncomplicated soft tissue closure.....	20
0801 simple or compound, open reduction or excision.....	35
0803 shaft, simple, closed reduction.....	20
0804 compound with uncomplicated soft tissue closure.....	25
0805 simple or compound, open reduction.....	40
0815 Ulna, shaft, closed reduction.....	20
0816 compound, with uncomplicated soft tissue closure.....	25
0817 simple or compound, open reduction.....	40

LOWER EXTREMITY

0883 Femur, simple or compound, open reduction.....	80
0904 Tibia, shaft, simple or compound, open reduction.....	50
0921 Fibula, shaft, closed reduction.....	15
0927 Tibia and fibula, shafts, compound with uncomplicated soft tissue closure.....	35
0934 Ankle, bimalleolar (including Potts) compound with uncomplicated soft tissue closure.....	30
0935 simple or compound, open reduction.....	50
0955 Astragalus, simple, closed reduction.....	20
0961 Os calcis, closed reduction.....	20
0976 Phalanx or phalanges, great toe, simple, closed reduction.....	5
0977 simple or compound, open reduction.....	15

Joints

ARTHROTOMY or capsulotomy with exploration, drainage, or removal of loose body, e.g., osteochondritis or foreign body.

1001 Shoulder.....	50
1002 Elbow.....	50
1003 Wrist.....	40

SCHEDULE OF SURGICAL OPERATIONS (Continued)

Code	AMOUNT	Code	AMOUNT
MUSCULOSKELETAL SYSTEM (continued)		1928	Classic submucous resection, nasal septum 30
1007	Hip 70	Accessory Sinuses	
1008	Knee 50	1981	Antrum lavage, unilateral, puncture or natural os- tium 2
1010	Ankle 50	1988	Radical antrotomy [Caldwell-Luc], unilateral . . . 50
1050	Sesamoid bone, excision, one or more, unilateral 15	1995	Combined external frontal, ethmoidal and sphenoidal sinusotomy, unilateral 80
ARTHRECTOMY—Excision of joint		Larynx	
1075	Excision of intervertebral disc with spinal fusion. 120	2051	Laryngectomy, without neck dissection 100
1082	Menisectomy: excision of semilunar cartilage of knee joint 50	2071	Laryngoscopy, direct, diagnostic (independent procedure) 10
ARTHROPLASTY—Plastic or reconstructive operation on joint, any type.		2074	including excision of tumor 25
1141	Shoulder 80	Trachea and Bronchi	
1142	Elbow 80	2111	Bronchoscopy, diagnostic 15
1143	Wrist 60	2113	with biopsy 20
1148	Hip, cup 100	2117	with removal of foreign body 25
1152	Ankle 75	2120	with excision of tumor 25
1159	Metatarsal—phalangeal joint; bunion operation, Silver type 20	2121	with therapeutic aspiration of bronchus 15
ARTHRODESIS—Fusion of joint		2123	with injection of contrast media 15
1166	Shoulder 90	Lungs and Pleura	
1167	Elbow 70	2151	Thoracotomy, exploratory, including biopsy . . . 50
1168	Wrist 60	2152	including control of hemorrhage and/or repair of lung fistula 75
1175	Hip 100	2154	with open drainage of empyema cavity by rib resection (independent procedure) 40
1177	Ankle 70	2193	Total or subtotal lobectomy 100
1178	Hammer toe operation, one toe 20	2194	Wedge resection, single or multiple 80
1211	Suture of torn, ruptured or severed collateral ligament, knee, one 55	CARDIOVASCULAR SYSTEM	
1212	Suture of torn, ruptured or severed cruciate ligament, knee, one 55	Heart and Pericardium	
1213	Suture of torn, ruptured or severed collateral and cruciate ligaments, knee 75	2301	Cardiotomy with exploration or removal of foreign body from myocardium 100
DISLOCATIONS		2314	Valvulotomy or commissurotomy, mitral 120
1286	Shoulder (humerus), simple or compound, open reduction 55	2315	aortic 150
1292	Elbow, simple or compound, open reduction . . . 55	2321	Pericardiectomy, extensive 100
1304	Metacarpal, one bone, simple, closed reduction . 3	VENOUS ANASTOMOSIS:	
1334	Hip (femur), simple or compound, open reduction 60	2526	Ligation of femoral vein 25
1346	Knee (femoral-tibial joint), simple or compound, open reduction 60	2530	Ligation and division of common iliac vein . . . 50
1350	Patello, simple, closed reduction 3	2558	Ligation and division of long saphenous vein at saphenofemoral junction with or without retrograde injection, or distal interruptions 20
1357	Ankle, simple or compound, open reduction . . . 50	2561	Ligation and division and complete stripping of long or short saphenous veins, unilateral 30
1376	Metatarsal, one bone, simple, closed reduction . . 7	2562	bilateral 50
Bursae		2563	long and short saphenous veins, unilateral . . . 40
1401	Drainage of infected bursa (incision) 3	2576	Ligation and division of short saphenous vein at saphenopopliteal junction (independent procedure) 12.5
1410	Removal of subtrochanteric calcareous deposits. 30	2581	minor varicose vein of leg, initial 5
Muscles		2585	subsequent 3
1495	Suture of ruptured diaphragm, transabdominal . . 70	LYMPHATIC SYSTEM	
1496	trans thoracic or combined 80	Lymph Nodes and Lymphatic Channels	
1550	Excision of lesion of tendon or fibrous sheath, or ganglion, digits only 10	2641	Biopsy or excision of lymph node (independent procedure), (except 2642) 5
1553	in other locations 15	2642	anterior scrota 15
Tendons, Tendon Sheaths and Fascia		RADICAL LYMPHADENECTOMY:	
1570	Fasciotomy, palmar or plantar, subcutaneous . . 10	2651	Supra-hyoid, unilateral 50
1573	Fasciotomy, for Dupuytren's contracture, partial radical, including finger extensions and vertical bands 50	2655	Cervical (complete), unilateral 80
1580	Repair or suture extensor tendon, hand or foot, distal to wrist or ankle, single 12	2658	Axilla 50
1582	forearm or leg 18	2671	Groin, superficial 50
1589	Lengthening or shortening tendon 30	DIGESTIVE SYSTEM	
1632	Patellar advancement 60	Pharynx, Adenoids and Tonsils	
1655	Suture of complete shoulder cuff avulsion 70	2992	Tonsillectomy, with or without adenoidectomy, under age 18 years 15
Extremities		2993	age 18 years or over 20
AMPUTATION			
1703	Disarticulation of shoulder 75		
1705	Arm through humerus 40		
1748	Disarticulation of hip 80		
1750	Disarticulation of knee 40		
1767	Leg, through tibia and fibula 50		
RESPIRATORY SYSTEM			
Nose			
1915	Excision of single nasal polyp 3		
1916	Excision of nasal polyps, multiple, unilateral or bilateral, one or more stages, office 7		
1917	complicated, requiring hospitalization 20		

SCHEDULE OF SURGICAL OPERATIONS (Continued)

Code	AMOUNT	Code	AMOUNT	
DIGESTIVE SYSTEM (Continued)		FEMALE GENITAL SYSTEM		
Esophagus		4488	Repair of cystocele, rectocele, and perineoplasty, anterior and posterior vaginal walls, with or without repair of urethrocele.	50
3043	Esophagectomy: resection of esophagus, transpleural or extrapleural (upper two-thirds).	4617	Total hysterectomy (corpus and cervix) with or without tubes, and or ovaries, one or both.	60
3051	Esophagoscopy, diagnostic.	4627	Radical hysterectomy for cancer, including regional lymph nodes.	100
3055	with biopsy.	4631	Vaginal hysterectomy, with or without pelvic floor repair, or abdominal hysterectomy followed by pelvic floor repair.	70
Stomach		4634	Trachelectomy; cervicectomy; amputation of cervix (independent procedure).	20
3112	Local excision of stomach ulcer or benign neoplasm.	4646	Dilation and curettage of uterus (independent procedure), under anesthesia, diagnostic or therapeutic, including cervical biopsy.	15
3114	Total gastrectomy.			
3117	Pyloroplasty and vagotomy.			
3121	Gastroscoy, diagnostic.			
3123	with biopsy.			
Intestines (Except Rectum)		THYROID GLAND		
3174	Enterectomy: resection of small intestine.	4911	Local excision of small cyst or adenoma of thyroid.	40
3178	Colectomy, partial resection of large intestine in two stages, including first stage colectomy or cecostomy.	4914	Thyroidectomy, total or complete.	70
3179	Colectomy, partial, with anastomosis with or without concomitant proximal colostomy.	4917	subtotal or partial.	60
3211	Enterolysis: freeing of intestinal adhesion.	4924	total or subtotal for malignancy with radical neck dissection.	100
Appendix		NERVOUS SYSTEM		
3261	Appendectomy.			
Rectum		Skull, Meninges, and Brain		
3291	Complete proctectomy, combined abdomino-perineal, one or two stages.	5119	Craniotomy for orbital decompression, unilateral.	100
3294	Excision of rectal procidentia, with anastomosis, perineal approach.			
		Spine and Spinal Cord		
Anus		5198	Spinal puncture, lumbar, simple (independent procedure).	2
3351	Fistulotomy or fistulectomy, subcutaneous.	5208	Laminectomy for removal of intervertebral discs, cervical.	90
3352	submuscular.	5209	dorsal.	90
3372	Cryptectomy, single, office.			
3374	Papillectomy or excision of single tab (independent procedure) office.	Peripheral Nerves, Other Extracranial Nerves, and Ganglia		
3377	Hemorrhoidectomy, external, complete.	5273	Excision of surgically identifiable neuroma of cutaneous nerve.	8
3380	internal and external.	5274	digital nerve, one or both, same digit.	10
3382	Fistulotomy or fistulectomy, submuscular, and hemorrhoidectomy.			
Biliary Tract		Vegetative Nervous System		
3515	Cholecystectomy.	SYMPATHECTOMIES:		
3517	with open exploration of common duct.	5371	Cervical, unilateral.	60
		5375	Cervico—thoracic (Smithwick type, supra- and infra-diaphragmatic), unilateral.	70
Abdomen, Peritoneum and Omentum		5385	Splanchnicectomy (Peet type) unilateral.	65
3631	Inguinal, unilateral.			
3646	Femoral, unilateral.			
3663	Epigastric.			
DIAPHRAGMATIC (see 1495, 1496)		EYE		
URINARY SYSTEM		Eyeball		
Kidney		5421	Enucleation of eyeball (bulb or globe) with or without sphere implant.	40
3808	Nephrotomy with drainage; nephrostomy.			
3811	Nephrolithotomy, removal of calculus.	Cornea		
3816	Pyelotomy with drainage, pyelostomy.	5457	Pterygium.	25
3821	Nephrectomy, including partial ureterectomy through same incision.	5465	Curettage and cauterization of corneal ulcer.	5
		5471	Keratoplasty: corneal transplant, lamellar.	100
		5472	partial or complete, penetrating.	110
Bladder		Sclera		
CYSTOSCOPY (independent procedure)		5501	Sclerectomy for glaucoma, with scissors, punch or trephination.	60
3930	Diagnostic, office, initial.			
3951	Litholapaxy: Crushing of calculus in bladder and removal of fragments.			
		Crystalline Lens		
Urethra		5611	Extraction of lens, intracapsular, extracapsular or linear, unilateral.	80
4000	Urethroscoy, diagnostic.	5616	Removal of dislocated lens.	80
		Lacrimal Tract		
		5811	Dacryocystectomy: excision of lacrimal gland.	50
		5813	Dacryocystectomy: excision of lacrimal sac.	50
		5815	Excision of lacrimal gland tumor.	60
MALE GENITAL SYSTEM		EAR		
4143	Orchiectomy, simple, unilateral.	Middle Ear		
4146	radical, unilateral or bilateral, with retroperitoneal gland dissection.	5971	Mastoidectomy, simple.	50
4201	Excision of hydrocele, unilateral.	5972	Mastoidectomy, modified radical or radical, without skin graft.	70
4311	Prostatectomy, perineal, subtotal.	5997	Stapes mobilization, primary or secondary.	70
4316	suprapubic, one or two stages.			
4319	radical.	Internal Ear		
4321	Transurethral resection of prostate, including control of post-operative bleeding, complete.	6011	Labyrinthotomy, any type.	100
		6012	Fenestration of semicircular canal.	100
		6021	Labyrinthectomy.	100

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the effective date of coverage of any covered member, no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy or for addition of coverage thereunder of any member after its date of issue, shall be used to avoid this policy with respect to any such covered member or deny a claim for loss incurred with respect to any such member more than two years after the effective date of coverage of such member. (b) No claim for loss incurred with respect to any covered member after the effective date of coverage of such member, shall be denied or reduced on the ground that a disease or physical condition not excluded by name or specific description effective on the date of such loss with respect to such member, had existed prior to the effective date of coverage of such member.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this policy shall continue in force.

REINSTATEMENT: If any renewal premium be not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this policy; provided, however, that if the Company or such agent requires an application for such reinstatement and issues a conditional receipt for the premium tendered, this policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Insured in writing of its disapproval of such application. This policy as reinstated shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the Insured and the Company shall have the same rights under this policy as reinstated as they had under this policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with a reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured to the Company at its Home Office in Los Angeles, California, or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time fixed in this policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS: Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under Parts 3 and 5 will be paid upon receipt of due written proof of loss. Subject to due written proof of loss, all accrued indemnities for loss under Parts 1, 2 and 4 will be paid at the expiration of each month, and any balance remaining unpaid upon the termination of liability will be paid upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to the Insured. Any accrued benefits unpaid at the Insured's death will be paid to the estate of the Insured. If any benefit of this policy shall be payable to the estate of the Insured, or to an Insured who is a minor or otherwise not competent to give a valid release, the Company may pay such benefit, up to an amount not exceeding \$1,000.00, to any relative by blood or connection by marriage of the Insured who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

PHYSICAL EXAMINATIONS: The Company at its own expense shall have the right and opportunity to examine the person of any covered member when and as often as it may reasonably require during the pendency of a claim hereunder.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. Other valid coverage shall mean coverage provided by individual or group insurance, or by automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

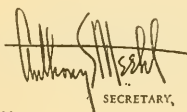
MISSTATEMENT OF AGE: If the date of birth of any covered member has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age of the covered member. However, if such member's age, based on the correct date of birth, was such on the date such member's coverage became effective that the Company would not have granted such coverage, the Company's liability with respect to that member shall be limited to refund of that part of the premium or premiums paid to the Company on account of that member.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy shall be binding upon the Company unless and until the original or a duplicate thereof is received by the Company at its Home Office in Los Angeles, California. The Company does not assume any responsibility for the sufficiency or validity of any assignment.

Occidental Life Insurance Company of California has executed this policy at Los Angeles, California, to take effect as of the date of issue.


SECRETARY

SPROUTMEN


PRESIDENT

Occidental Life

Insurance Company of California

HOME OFFICE: Los Angeles

A Member of
Transamerica Corporation

NOTICE: In collecting any benefit under this policy, it is not necessary to employ any person or agency. Write direct to the Company at Occidental Center, Los Angeles, California, and thus save unnecessary expense.

HOSPITAL AND MEDICAL EXPENSE POLICY

Guaranteed Renewable to Age 65 but Not Beyond Eligibility for Medicare

Premium Rate Subject to Change

POLICY GC-22

PLEASE READ YOUR POLICY

5-970 58-166

CONVERSION PRIVILEGE**U.S. MEDICAL POLICIES**

A conversion privilege will be included in the policy which may be elected by an employee or member whose insurance terminates because he ceases to be eligible for insurance (other than because of attainment of the age of eligibility for Medicare) while the policy continues in force. The same conversion privilege will also be extended to a child whose insurance terminates because he attains the upper age limit specified for dependent children. Such individual may, by applying and paying his premium within 31 days of termination, convert without evidence of insurability to the specific conversion plan applicable to the policy. *No person who has attained the age of eligibility for Medicare may be insured under a converted policy.*

The converted policy will become effective on the termination date of the insurance under the group policy and will cover the individual, and, if he elects to cover his dependents, all of his dependents who were insured under the group policy at the time of termination. If termination is because of the individual's death, the surviving spouse may convert the dependents insurance in force at the individual's death. Under the laws of some states children may be included as dependents under a converted policy only until age 18, and any children over 18 but under 19 who were covered under the group policy may not be included as dependents under the converted policy. Any child under age 19 who was covered under the group policy and cannot be covered as a dependent under the converted policy may be covered under a separate converted policy issued to him. The rate for such policy will be the age 19 rate.

There is no extension of insurance under the group policy during the conversion period such as is provided for group life insurance.

An insured's conversion policy will not be subject to cancellation for deterioration of health. The policy will contain an "insurance with other carriers" provision enabling the company to pro-rate benefits in cases of overinsurance resulting from similar coverage with other carriers.

CONVERSION PLANS AVAILABLE

The plans available and the conversion premiums are shown in the "Group Medical Expense Conversion Privilege" brochure GMM-1075B.

COORDINATION OF BENEFITS

For over 30 years, basic group medical expense benefits were provided without regard for any other medical coverage which the insureds might have. For many years, it appeared that only a small percentage of insured employees had other coverage. Also, the group benefits were usually so limited that an employee could supplement them without receiving total benefits which could encourage malingering.

Eventually, with the growth of group medical expense coverage, overinsurance became a serious problem. Under liberal basic plans and/or major medical policies, both the employee and his dependents often have adequate protection against most kinds of medical expense. In addition, due to the substantial proportion of working wives and the practice of insuring husbands as well as wives, a great many families are insured under two group plans.

Working wives and insured husbands had been recognized by the time major medical insurance was developed. To avoid duplicate payment of major medical benefits, most group policies excluded the benefits payable under any other group or governmental plan from the Covered Expense to which the scheduled deductible and coinsurance were to be applied. Usually an employee received the regular benefits under his employer's plan and reduced benefits under the plan which covered his (or her) spouse as an employee; the children's claims were paid first under the father's insurance and on the reduced basis under the mother's. There were many exceptions, however, some due to differences in practice among the insuring companies and some due to lack of knowledge as to the other insurance to which an employee was entitled.

The greatest flaws in the anti-duplication provisions were (1) that they applied only to major medical benefits and had no effect on the basic benefits, (2) that the persons insured often felt deprived of benefits to which they considered themselves entitled by the payment of premiums on their account under both plans, and (3) even with duplicate coverage, employees frequently received less than 100% reimbursement for their medical expenses.

These and many other aspects of the overinsurance problem were carefully studied by an Industry Study Group on Non-duplication of Accident and Health Insurance Benefits. This group, consisting of representatives of the American Life Convention, the Health Insurance Association of America and the Life Insurance Association of America, developed a model group medical expense anti-duplication provision which has been accepted as a practical solution to the problem by almost all the insurance companies.

This provision is the basis for Occidental's Coordination of Benefits provision. The intent is, to the extent practicable, to limit the amount an insured person will receive on account of medical expenses to the amount of those expenses.

Classification: General Information—Health.

Subject: Health Group Conversions—U.S. and Canada.

This instruction supersedes SAV G-AS 139, dated February 28, 1967 and SAV G-H 162, dated February 1, 1968. The purpose of this instruction is to authorize Policy HC-2 for persons age 65 or over or eligible for Medicare, as noted in Section IV. SAV G-AS 139 has been incorporated as Section III of this instruction, and applies only as stated herein.

Effective with policies dated on and after July 1, 1967, the rates and plans described in this Instruction for the U.S. will be used. This instruction also shows increased rates for the GC-20Z plan in Canada. The increase is authorized in another instruction, and the new rates are being shown here.

I. CONVERSION PRIVILEGE

Some of the group contracts issued by this Company contain a "Conversion Privilege," which entitles insured persons to apply for a policy insuring for medical expense benefits on a form customarily issued by the Company for conversion purposes, upon termination of group coverage. This privilege is extended only when it is specifically provided for by the group contract.

Certain group master policies require that the plans and rates described in Section III be offered instead of the plans and rates described in Section II. Group Accounting will notify Policy Change when such is the case. Premiums will be increased on the first policy anniversary in accordance with regular procedures to the then effective premium rates for such plans.

II. PLANS OF COVERAGE—U.S.—UNDER AGE 65 AND NOT ELIGIBLE FOR MEDICARE

A. Four plans of coverage are available for persons under age 65 and not eligible for Medicare. The plans are based on the amount of the Daily Hospital Expense Benefit provided. The employee may select any plan which provides the same, or any lower, Daily Hospital Expense Benefit compared to the employee's benefit under the group plan. Dependents will receive the same benefits as the employee, regardless of the benefits provided under the group plan.

B. Benefits are provided on a reimbursement basis for accident or sickness, as follows:

1. Daily Hospital Expense.

All plans provide up to 31 times the Daily Hospital Expense Benefit for room, board and general nursing care. Daily Hospital Expense Benefits are as follows, for insured and dependents:

Plan 1.....	\$14.00
Plan 2.....	20.00
Plan 3.....	26.00
Plan 4.....	32.00

2. Miscellaneous Hospital Expense.

All plans provide up to 15 times the Daily Hospital Expense Benefit, graduated according to the number of days confined in the hospital.

3. Ambulance.

All plans provide up to the Daily Hospital Expense Benefit (for one day) for each period of hospital confinement, for ambulance transportation.

4. Surgery.

The surgery schedule in the policy is from the 1960 California Relative Value Studies, and unit values are shown rather than dollar amounts. To obtain the dollar amount for a procedure it is necessary to multiply the unit value by the Surgical Factor. The Surgical Factors are as follows:

Plan 1.....	\$3.00
Plan 2.....	3.50
Plan 3.....	4.00
Plan 4.....	4.50

5. Doctor's In-Hospital Visits Expense.

The amount provided for each day a professional visit is made and the maximum per disability are:

	Each day	Maximum per disability
Plan 1.....	\$4.00	\$124.00
Plan 2.....	5.00	155.00
Plan 3.....	6.00	186.00
Plan 4.....	7.00	217.00

C. Policy Forms are to be employed as follows:

Use GC-22 for all plans and for all ages, for individual or family coverage.

D. Premium rates are shown at the end of the Instruction.

E. Renewability of GC-22.

The insurance with respect to the Insured is guaranteed renewable to his 65th birthday but not beyond eligibility for Medicare benefits. (Public Law 89-97, Health Insurance for the Aged Act, as amended.) The insurance with respect to the spouse of the Insured is guaranteed renewable to her 65th birthday but not beyond eligibility for Medicare benefits and not beyond the end of the term during which the spouse is divorced or legally separated from the Insured. The insurance with respect to a dependent child is renewable to the end of the term during which the child attains age 22, marries or ceases to be a dependent of the Insured.

F. Some group certificates may list the benefits available upon conversion. This list may differ from the benefits available on the GC-22 plans. However, conversions will be issued in accordance with these instructions unless an objection is raised by the individual converting. When an objection is raised the matter will be referred to the Actuarial Department.

III. SPECIAL PLANS OF COVERAGE—U.S.

A. Four Plans of coverage are available. The plans are based on the amount of the Daily Hospital Expense Benefit provided. The plan to be offered is that which provides the same, or the next lower, Daily Hospital Expense Benefit compared to the employee's benefit under the group plan. Dependents will receive the same benefits as the employee, regardless of the benefits provided under the group plan. The employee has *no option* with regard to the different plans or benefit.

B. Benefits are provided on a reimbursement basis for accident or sickness as follows:

1. Daily Hospital Expense.

All plans provide up to 31 times the Daily Hospital Expense Benefit for room, board and general nursing care. Daily Hospital Expense Benefits are as follows, for insured and dependents:

Plan 1-----	\$10. 00
Plan 2-----	14. 00
Plan 3-----	18. 00
Plan 4-----	22. 00

2. Miscellaneous Hospital Expense.

All plans provide up to 15 times the Daily Hospital Expense Benefit, graduated according to the number of days confined in the hospital.

3. Ambulance.

All plans provide up to the Daily Hospital Expense Benefit (for one day) for each period of hospital confinement, for ambulance transportation.

4. Surgery.

The surgery schedule in the policy is from the 1960 California Relative Value Studies, and unit values are shown rather than dollar amounts. To obtain the dollar amount for a procedure it is necessary to multiply the unit value by the Surgical Factor. The surgical factors are as follows:

Plan 1-----	\$2. 50
Plan 2-----	3. 00
Plan 3-----	3. 50
Plan 4-----	4. 00

5. Doctor's In-Hospital Visits Expense

Plans 1 and 2 provide for up to \$3.00 each day a professional visit is made, with a maximum of \$93.00 per disability. Plans 3 and 4 provide for up to \$4.00 each day a professional visit is made, with a maximum of \$124.00 per disability.

C. Policy forms are to be employed as follows:

Use GC-22 for all plans and for all ages, for individual or family coverage.

D. Premium rates are shown at the end of this instruction. Premium shall be increased on the first policy anniversary in accordance with established procedure for the increase.

IV. PLANS OF COVERAGE—U.S.—AGE 65 OR OVER OR ELIGIBLE FOR MEDICARE

Persons who are age 65 or over or who are eligible for Medicare benefits will be issued Policy HC-2, with a \$10 Daily Hospital Indemnity.

V. PLANS OF COVERAGE—CANADA

Conversion is available only to residents of Ontario and Quebec. Conversion shall not be available to residents of Ontario for any case where the Policy would be dated on or after October 1, 1969, and to residents of Quebec for any case where the policy would be dated on or after July 1, 1970.

A. Daily Hospital Room benefit.

Up to \$5.00 daily, for up to \$155.00 per disability. This will apply only to the excess over the room coverage provided by the Provincial plan.

B. Ambulance.

Up to \$10.00 per disability.

C. Surgery.

Either \$200.00 or \$300.00 schedules, where all persons insured are under age 66, or a \$200.00 schedule where any covered member is age 66 or over. The selection of \$200.00 or \$300.00 when all members are under 66 will depend upon the requirements of the Group master policy involved, and is not the option of the converting applicant. The basic schedule is the G.S.S.2.

D. Doctor Calls (Non-Surgical)

Up to \$5.00 daily, for up to \$155.00 per disability.

E. Accident X-ray Expense

Up to \$25.00 per disability for X-ray expense not covered under a Provincial Hospital plan, which is incurred on account of accidental injury.

NOTE: Benefits (A) and (E) are conditioned upon the eligibility of the Insured for Provincial coverage, and do not depend upon whether he actually has such coverage.

Policy GC-20Z will be used for either individual or family coverage.

RENEWAL UNDERWRITING (CANADA ONLY)

1. Foreign Residence

The policy should be marked for non-renewal at the next premium due date if it is learned that the Insured is to be away in a foreign country for a period

of time in excess of 4 months. The Group Contract provides for conversion at the option of the Insured, and so the conversion must be effective regardless of the place of residence at the date of conversion.

2. *Advanced Age*

For ages under 78 at date of conversion, it will be permissible to renew the policy through 79 subject to 3. below. For age 78 or older, records should be marked so that the policy will not be renewed after two years.

3. *Post Claim Underwriting*

Converted policies referred to the Underwriting Department for possible non-renewal action are to be handled in the same manner as any other A & S policy as regards post claim underwriting, in accordance with the Claims-Premium Ratio Schedule net as a guide for the Underwriting Department.

4. *First Year Non-Renewal*

No non-renewal action is to be taken within the first year after conversion, for reasons of health or claims experience.

VI. ELIGIBILITY OF DEPENDENTS

Dependents covered under the employee's group plan may be included in the converted policy. This means that an employee with dependents included in the group policy may apply for a converted policy on his own life only, or he may apply for a converted policy for himself and such dependents. However, if any such dependent is to be covered under the converted policy, all such dependents must be covered. This is in accordance with legal requirements governing the language of the group master contracts. Dependents not covered under the group plan cannot be included in the converted policy at the date of conversion. Such dependents may be added subsequent to the date of conversion, on application and submission of satisfactory evidence of insurability. The regular application form for adding additional dependents to hospital policies will be used. Dependent children age 19 or over are not eligible under the converted policy, regardless of the definition of dependents in the group policy except that we will consider a dependent, no longer eligible as a dependent, for an individual policy.

VII. EFFECTIVE DATE OF COVERAGE

Effective date of coverage of the converted policy will be the day following termination of insurance under the group policy. Applications postmarked after the 31 day conversion period will not be accepted without satisfactory evidence of insurability unless an extension has previously been granted under Company rules.

VIII. CONVERSION UPON DEATH OF EMPLOYEE

If an insured employee dies, a surviving spouse may convert coverage, including that of any other covered dependent. Such spouse will be treated as a male or female employee for computation of premium. If dependents are included, the rate shall be that for employee and children.

IX. POLICY TO BE ISSUED

When a person entitled to a GC-22 or HC-2 plan is a U.S. resident, he shall be issued a policy according to the state in which the conversion application was signed regardless of the state in which the master group policy was issued, or regardless of the state in which he worked or resided while his group insurance was in force. Likewise a person entitled to a GC-20Z plan will be issued coverage according to the province in which his application was signed.

In some instances one master policy will cover units in both the U.S. and Canada. The U.S. Units will have customary U.S.-Type Coverage and the Canadian Units will have customary Canadian-Type Coverage. When this situation occurs, those persons who are members of the U.S. units will receive a GC-22 or HC-2 plan, and those persons who are members of the Canadian unit will receive a GC-20Z plan.

If a person entitled to a GC-22 or HC-2 plan indicates that he is becoming a resident of Canada, he shall be given instead a GC-20Z plan with a \$300 surgery schedule. If a person entitled to a GC-20Z plan indicates that he is becoming a resident of the U.S., he will be given a GC-20Z plan and the policy will be endorsed to provide for payment in U.S. currency.

If a person indicates that he is becoming a resident of any other country, he will be issued the proper plan to which he is entitled and informed that premium payments and benefits must be made in the currency of the policy.

X. KIND CODES

The following kind codes have been assigned to converted group policies described in this instruction.

Code and Form :

954 GC-20Z (Canada)—Individual
 967 GC-20Z (Canada)—Family
 971 GC-22—Individual
 972 GC-22—Family
 975 GC-22—Special—Individual
 976 GC-22—Special—Family
 480 HC-2—Individual (Show source code as 41)

XI. WHEN CHANGES IN MASTER POLICY PROVISIONS PERTAINING TO CONVERSION BENEFITS ARE MADE BY THE GROUP UNDERWRITING DIVISION, THEY WILL INFORM THE ACTUARIAL DEPARTMENT SO THAT ANY NECESSARY CHANGES MAY BE MADE IN CORRESPONDING PROVISIONS OF CONVERTED POLICIES.

XII. THE GROUP UNDERWRITING DIVISION WILL BE RESPONSIBLE FOR KEEPING EMPLOYEES AND ADMINISTRATORS OF MASTER CONTRACTS INFORMED OF CHANGES IN CONVERSIONS, PRIVILEGES AND BENEFITS. THE POLICY DRAFTING SECTION OF THE ORDINARY ACTUARIAL DEPARTMENT WILL BE RESPONSIBLE FOR POLICY FORMS AND RIDERS TO BE USED FOR CONVERSIONS.

Premium rates

Annual premiums are shown. Premiums may also be paid semi-annually or quarterly. Semi annual and quarterly premiums are one-half and one-quarter respectively of the annual premium, plus \$.50. How pay loading is added to the hospital premium for premium field distribution. On family policies, the loading is added once to the total premium for all members.

GC-22 PLANS DESCRIBED IN SECTION II

Age	Plan I	Plan II	Plan III	Plan IV
Adult male covered member:				
To 39.....	\$96	\$120	\$136	\$150
40-49.....	136	168	190	222
50-59.....	158	198	228	268
60-64.....	174	214	252	292
Adult female covered member:				
To 39.....	150	182	214	244
40-49.....	158	190	222	252
50-59.....	168	198	228	268
60-64.....	174	214	252	292
Dependent children (1 or more) to 19.....	128	150	174	198

GC-20Z

Age	Plan A \$200 surgery	Plan B \$300 surgery
Adult male covered member:		
To 50.....	\$33	\$39
51-60.....	45	53
61-65.....	73	83
66-70.....	73	83
71-80.....	89	99
Adult female covered member:		
To 50.....	50	60
51-60.....	60	720
61-65.....	84	95
66-70.....	84	95
71-80.....	99	119
Dependent children (1 or more) to 19.....	33	39

ANNUAL PREMIUMS—SPECIAL GC-22 PLANS DESCRIBED IN SECTION III

	Age to 39	40-49	50-59	60-64
Male (employee or husband):				
Plan 1:				
Hospital	\$39.20	\$59.20	\$71.76	\$80.58
Surgical	16.80	20.80	20.24	21.42
Total	56.00	80.00	92.00	102.00
Plan 2:				
Hospital	49.00	73.50	90.48	100.80
Surgical	21.00	24.50	25.52	25.20
Total	70.00	98.00	116.00	126.00
Plan 3:				
Hospital	56.80	85.12	105.86	119.88
Surgical	23.20	26.88	28.14	28.12
Total	80.00	112.00	134.00	148.00
Plan 4:				
Hospital	63.36	100.10	126.40	141.04
Surgical	24.64	29.09	31.60	30.96
Total	88.00	130.00	158.00	172.00
Female (employee or wife):				
Plan 1:				
Hospital	61.60	67.16	73.50	80.58
Surgical	26.40	24.84	24.50	21.42
Total	88.00	92.00	98.00	102.00
Plan 2:				
Hospital	74.20	81.76	87.00	100.80
Surgical	31.80	30.24	29.00	25.20
Total	106.00	112.00	116.00	126.00
Plan 3:				
Hospital	89.46	96.20	103.18	119.88
Surgical	36.54	33.80	30.82	28.12
Total	126.00	130.00	134.00	148.00
Plan 4:				
Hospital	103.68	111.00	123.24	141.04
Surgical	40.32	37.00	34.76	30.96
Total	144.00	148.00	158.00	172.00

Note: Premiums shall be increased on the first policy anniversary in accordance with established procedure for the increase.

	Plan 1	Plan 2	Plan 3	Plan 4
Children:				
Hospital	\$40.70	\$48.40	\$56.10	\$63.80
Surgical	33.30	39.60	45.90	52.20
Total	74.00	88.00	102.00	116.00

HC-2 PLAN DESCRIBED IN SECTION IV

Age	Male	Female
65 to 69	\$75	\$67
70 to 74	86	77
75 to 79	99	89
80 to 84	114	103
85 to 89	126	113

(Countersigned) JOHN O. MONTGOMERY,
Assistant Actuary.
 (Signed) RAYMOND H. BIERSEBACH,
Vice President and Associate Actuary.

Classification: General Information—Health.

Subject: Conversions other than group conversions—United States.

This instruction supersedes SAV Instruction No. G-H 219, dated October 2, 1969. This instruction revises the instructions given at the beginning of Paragraph A2, and also describes the use of Endorsements 5-004 58-164, 5-005 58-165 and 5-000 58-166.

Certain policies issued by this company contain conversion provisions under which a new policy shall be issued without evidence of insurability upon automatic termination of coverage under the original policy. The GH-2 and MM-1, 2, and 3 policies, which do not have such provisions, have had the conversion feature extended to them as provided in this instruction. The purpose of this instruction is to set forth all the conversion rules.

A. HOSPITAL AND MEDICAL EXPENSES

1. When coverage of the Insured or spouse is being terminated under one of the plans listed below, either because of attaining age 65 or because of becoming eligible for benefits under Medicare, Policy HC-2 with a \$10.00 daily hospital indemnity shall be offered whether termination of coverage is automatic under the terms of the policy or is voluntary at the request of the Insured.

The preceding instruction shall apply to the following plans:

GH-2 ¹	MM-1 ¹	FD-2 or FD-3, but only when Rider 5-027 58-162 or Rider
GH-4	MM-2 ¹	5-028 58-162 is attached.
GH-10	MM-3 ¹	
GH-365	MM-4 ¹	
	MM-10	

¹ Coverage does not automatically terminate on these policies. HC-2 will be offered on voluntary cancellation of coverage.

2. If coverage is being automatically terminated under the terms of the policy because of termination of dependency or marriage of a dependent child or divorce or legal separation of the Insured and Spouse, offer as follows:

<u>If Original Policy Is</u>	<u>Offer</u>
¹ GH-2, with or without surgery-----	GH-10, same DHB, \$4 unit (\$600 max.) surgery
GH-4 and GH-10-----	² GH-10, same DHB and surgery
GH-365-----	GH-365, same daily hospital indemnity
MM-4 and MM-10-----	MM-10, same benefits
FD-2 } with 5-027 58-162-----	GH-10 with \$10 DHB, \$4 unit (\$600 max.) surgery
FD-3 }-----	
FD-2 } with 5-028 58-162-----	GH-10 with \$15 DHB, \$4 unit (\$600 max.) surgery
FD-3 }-----	
MM-1 }-----	
MM-2 } plans: -----	MM-10 as follows:
MM-3 }-----	
\$25 DHB-----	\$25 DHB
\$500 deductible-----	\$500 Deductible
\$1,000 surgery or \$750 surgery-----	\$7 unit (\$1,050 max.) surgery
\$7,500 max. ben. am't-----	\$10,000 max. ben. am't.
\$25 DHB-----	\$25 DHB
\$250 deductible-----	\$250 deductible
\$750 surgery or \$500 surgery-----	\$7 unit (\$1,050 max.) surgery
\$7,500 max. ben. am't-----	\$10,000 max. ben. am't.
\$15 DHB-----	\$15 DHB
\$500 deductible-----	\$500 deductible
\$1,000 surgery or \$750 surgery-----	\$5 unit (\$750 max.) surgery
\$7,500 max. ben. am't-----	\$7,500 max. ben. am't.
\$15 DHB-----	\$15 DHB
\$250 deductible-----	\$250 deductible
\$750 surgery or \$500 surgery-----	\$5 unit (\$750 max.) surgery
\$7,500 max. ben. am't-----	\$7,500 max. ben. am't.

¹ If the DHB is less than \$10.00, do not offer conversion.

² If the original coverage included a major medical rider, the converted policy may contain such a rider.

If coverage is in force under both a GH-2 and an MM-1, MM-2 or MM-3 policy, offer GH-10 with a major medical rider as follows:

Offer a GH-10 with the same DHB as the GH-2, and with a \$4 unit (\$600 max.) surgery and a major medical rider. If the DHB of the GH-2 is less than \$15, offer GH-10 with a \$15 DHB regardless.

Some of the above policies do not contain any conversion provisions, some of them have limited conversion provisions (e.g., only for terminating dependent children, etc.) and some have conversion provisions for any covered member whose coverage is automatically terminating. The conversion feature in all cases has been extended to all persons whose coverage is automatically terminating.

Add Endorsement 5-004 58-164, in those states in which it is approval for use, where the coverage of the stated covered member is converted from the following policies:

Policy and Automatic Termination of Covered Member:

GH-4 -----	Dependent Child.
GH-10 -----	All.
MM-4 -----	Dependent Child.
MM-10 -----	All.

Rider 5-027 58-162, or 5-028 58-162 (a) Policy issued upon death of Insured if spouse is a covered member.

(b) Dependent Child at Age 22.

Add Endorsement 5-006 58-166, in those states in which it is approved for use, to all other hospital and medical expense conversions or exchanges except that when the new policy is GH-365 or HC-2, no Endorsement shall be added. No Endorsement is available as yet suitable for use with GH-365 and none is required with HC-2.

If the Covered Member is over age 60 but not yet age 65 when coverage terminates under the original policy, charge the premium for age 60 and offer the appropriate policy as described on the preceding page.

B. DISABILITY INCOME

The disability income protection policy GR-20 provides for conversion at the end of the income protection period provided the Insured is not then totally disabled. Offer Policy GR-4 (without partial disability) as follows:

Offer a GR-4 with one-half the disability income of the GR-20, same elimination period as the GR-20, 2 year benefit period.

Add Endorsement 5-005 58-165 in those states in which it is approved for uses.

C. GENERAL INSTRUCTIONS

1. The converted policy shall be dated the day following termination of coverage under the original policy, and premiums shall be for the age of each covered member of that date. The policy may not be dated to save age.

It may happen that an event has occurred (such as marriage or termination of dependency of a child, or divorce of the spouse) during a prior term, and that under the provisions of the policy the coverage of such person terminated automatically at the end of such prior term. Under these circumstances, conversion shall be available as follows:

a. If the Insured wants the converted policy to be dated currently, it will be necessary to terminate coverage under the original policy currently. No premium shall be refunded to a date prior to the date of the converted policy.

b. If the Insured demands a refund of premium back to the time of the event and this is allowed under the rules governing termination of covered member status, such refund shall be granted. However, the conversion shall then be made effective the date to which premiums are refunded and the premium for the converted policy shall be charged from that date.

2. The Time Limit on Certain Defenses shall be interpreted from the effective date of coverage under the original policy.

3. Benefits shall not be payable under both the original coverage and the converted policy.

4. Optional additional benefits cannot be carried over to the new converted policy, except the major medical rider as covered in this instruction.

5. No special kind codes shall be assigned to conversions. Use the same kind code as for new issues of the same plan.

6. When the Company is notified of an event requiring termination of coverage and such notice is received during the last two weeks of the grace period of a premium, two weeks shall be allowed from the date the forms are mailed from the Company to return them to the Company.

7. Many family policies were issued with a provision substantially as follows:

Attainment of age 22 shall not operate to terminate the coverage of a dependent child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (b) chiefly dependent upon the Insured for support and maintenance.

This provision applies even though the policy as issued does not contain such a provision. This provision shall not prevent the termination of coverage for reasons other than attainment of age, for example, marriage or becoming eligible for benefits under Medicare. When coverage automatically terminates after having been continued under this provision, the appropriate conversion policy shall be offered.

8. Commissions for the new policy issued on a conversion of terminating coverage shall be the same as the commissions for new business.

D. TERMINATION PROVISIONS

Coverage is automatically terminated under the following policies as indicated:

1. Policy GH-2:

Dependent child—at the end of the term during which the child ceases to be dependent, marries or attains actual age 22; or at the end of the term during which the Insured and his spouse are divorced or legally separated, provided such divorce or legal separation terminates legal responsibility of the Insured for the care and support of the child who, except for such divorce or separation, would be a covered member.

Spouse of the Insured—at the end of the term during which such spouse becomes divorced or legally separated from the Insured.

2. Policy GH-4:

Dependent child—at the end of the term during which the child attains age 22 years or marries; or during which the Insured, while living, ceases to be legally responsible for the care and support of the child.

Spouse of the Insured—at the end of the term during which the spouse of the Insured is divorced or legally separated from the Insured.

3. Policy GH-10:

Dependent child—at the end of the term during which the child attains age 22 years or marries; or during which the Insured, while living, ceases to be legally responsible for the care and support of the child.

Spouse of the Insured—on the 65th birthday of the spouse or upon becoming eligible for benefits under Medicare; or at the end of the term during which the spouse is divorced or legally separated from the Insured.

Insured—on the 65th birthday of the Insured or upon becoming eligible for benefits under Medicare.

4. Policy GH-365 (form 5-520 58-267 only):

Same termination provisions as GH-10.

5. Policy GH-365 (form 5-520 58-168 only):

Dependent child—at the end of the term during which the child attains age 22 years or marries; or during which the child becomes no longer living in the Insured's household except while attending an educational institution.

Spouse of the Insured and Insured—same termination provisions as GH-10.

6. Policy MM-1, MM-2, MM-3:

Dependent child—at the end of the term during which the child attains actual age 22 or marries prior thereto; or at the end of the term during which the Insured and his spouse are divorced or legally separated, provided such divorce or separation terminates legal responsibility of the Insured for the care and support of the dependent child who, except for such divorce or separation, would be a covered member.

Spouse of the Insured—upon payment of the maximum benefit amount on account of the spouse at age 65 or over; or at the end of the term during which the spouse becomes divorced or legally separated from the Insured.

Insured—upon payment of the maximum benefit amount on account of the Insured at age 65 or over.

7. Policy MM-4:

Same termination provisions as GH-4.

8. Policy MM-10.

Same termination provisions as GH-10.

9. Riders 5-027 58-162 and 5-028 58-162:

Dependent child—at the end of the term during which the child attains age 22 years or marries; or during which the Insured ceases to be legally responsible for the care and support of the child.

Spouse of the Insured—at the end of the term during which the spouse is divorced or legally separated from the Insured.

Death of the Insured—coverage on covered dependents terminates at the end of the term during which the death of the Insured occurs. In this situation, the conversion provision applies only if the spouse of the Insured is a covered dependent under the rider.

NOTE: Riders 5-027 58-162 and 5-028 58-162 are only issued with policies FD-2 and FD-3.

(Signed) RAYMOND A. BIERSCHBACH,
Vice President and Associate Actuary.

MAY 26, 1972.

SENATOR PHILIP HART: I just read Jack Andersons "Secret Data Rept on Health Risks" and it really hit home with me. I have Lymphsarcoma and I found out just how bad an insurance company will treat you when you need them. I worked for eight years before I became ill and had a group policy. When I had to use it, it paid good but when I had to convert it to an individual policy they sent me a little surgical policy not worth anything to me and all things were cut to practically nothing. And I would have to be a surgical patient for it to pay even that. Of course no other company will insure me and knows a surgical policy is no good to a person with Lymphsarcoma. I wrote to them and told them I thought I should have the same type policy as I had before I became ill but it didn't do any good.

Keep working on them. I hope you can help people like me that need insurance. As long as we dont need any they will sell us all we can buy but when we really need it they cut us off with nothing and get away with it.

Thank you,

ADELL M. NIXON,
Hermitage, Arkansas.

P.S.—If I can help in any way, let me know.

SIDNEY, OHIO, May 5, 1972.

Senator PHILIP A. HART,
Chairman, the Senate Antitrust Subcommittee,
Washington, D.C.

DEAR SENATOR HART: I rarely write our Senators or Congressmen, however your position, as quoted in The Dayton Journal Herald of Monday, May 1st. was so strongly in keeping with my sentiments that I am compelled to commend and thank you for furthering this much needed correction within the Insurance Industry.

Several years past I had a coronary where considerable expense was taken care of through the Insurance Policy of the Corporation where I was employed. I recently retired and no longer have the full benefits of a Corporate program as when I was actively employed and, further, had to pay approximately \$600. for a medical policy whose benefits were far less than that which I enjoyed while actively employed. This, too, does not seem equitable but is somewhat beyond the point.

For months now I have been receiving, almost daily solicitations for Hospitalization Insurance and was interested because of my previous coronary and the high cost of hospitalization and treatment, but all of them have a restriction of from one to two years probation against any coverage for a previous illness.

A copy of your statement from the Dayton Journal Herald is attached and I heartily subscribe to every point you have made and sincerely hope that you will be successful in having corrections made.

Certainly the profits of the Insurance Companies and the monumental new buildings they are erecting all over the country confirms your very realistic approach to their not providing the protection where it is most needed.

One area where this might be resolved, at least in part, would be that if the employer did not or could not contribute to the original coverage in effect during

active employment, then the Insurance Company would be compelled to continue on the same coverage benefits which the retired employee would pay for at the employers group rate. I know that in my case this would spare me several hundred dollars due to a five day hospital treatment period which bill totalled \$653.00 and this without Doctor's bill. For your edification, I retired at age 64 in order to avoid the stress and strain of the times.

Again, our thanks to you for endeavoring to bring your program about at an early date.

Sincerely yours,

RUDOLF G. BERG.

Mr. SHARP. That is fine. We appreciate your cooperation. According to your conversion brochure, which you did submit to us, a man and wife, each aged 50, and one or more children, would have to pay \$734 a year for this coverage, and it will provide only \$32 a day toward room and board charges. Whereas, the average room and board rate is probably double that or more in California. Is that correct?

Mr. BIRSCHBACH. I don't know what the average room and board charge is.

Mr. SHARP. Well, we have the figures for 1971 reported by the American Hospital Association. The average countrywide hospital inpatient charge per patient per day was \$97 a day.

[From the Washington Evening Star, May 31, 1972]

HOSPITAL \$97 A DAY

New York—The American Hospital Association reports the cost of the hospital of inpatient care for one person for one day averaged over \$97 in 1971, a 12.7 percent rise over 1970.

Now, as to the rates in California, do you have any idea as to whether the rates in California would be more or less than that?

Mr. BIRSCHBACH. I would think the rates might be a little higher in southern California than the national average.

Mr. SHARP. If the person covered under the policy had a catastrophic illness, this plan, according to our calculations, would pay only \$2,364; yet, of course, we all know that illness costs a lot more than that.

Do you have any comment on why the benefits offered under your individual conversion plan are far less than those offered under the group policy that the employee had when he was working?

Mr. BIRSCHBACH. Well, as I say, I have not studied in detail the provisions of the group conversion policy.

Mr. SHARP. You are the actuary.

Mr. BIRSCHBACH. The earlier statement I made, sir, about voluntary insurance, the individual is covered under a group. There are certain assumptions as to the health of the person who is working.

You would assume that chances are he is in reasonably good health. Our experience is that on the loss ratio on group conversion policies is very high and it is—

Mr. SHARP. Excuse me. What does that mean, "loss ratio"?

Mr. BIRSCHBACH. The ratio of benefits paid to premiums paid.

Mr. SHARP. The amount you are paying on the claim is high? You are paying the people more, you mean?

Mr. BIRSCHBACH. As a percentage of the premiums taken in, yes.

This goes—I am more familiar with conversion of life insurance than I am with health insurance, and I know that the mortality rate

in converted group life policies is much higher than in straight individual life policies.

Mr. SHARP. But on life insurance it is my understanding that they charge a standard rate on a converted policy, isn't that true? If I convert my group life to an individual life, I am charged a standard rate, isn't that true?

Mr. BIERSEBACH. You are charged a standard rate, and if you convert your group health policy you are charged a standard group conversion rate.

Mr. SHARP. Which is more?

Mr. BIERSEBACH. It is different because there are different benefits.

Mr. SHARP. They are not charged a standard rate under group health. When I convert from group health to individual, I am not charged a standard group health rate.

Mr. BIERSEBACH. You have a different policy, an individual policy, and you are charged a standard rate for the group conversion policy.

Mr. SHARP. But it costs more than a similar individual policy would cost, isn't that true?

Mr. BIERSEBACH. That is probably true.

Mr. SHARP. Now, perhaps you would submit figures to the subcommittee showing comparable costs on converting from a group health policy to a——

Mr. BIERSEBACH. I would like to add one point to this discussion if I could.

Mr. SHARP. Yes, sir.

Mr. BIERSEBACH. If we could supply the same sort of coverage that the original group policy provided to those converting and include the cost of their coverage in the group premium and could spread the costs, if you would, back to the group case, we would be delighted to do so. But I find that the group carrier, is more interested in covering his active employees and it would greatly increase the total cost if he had to pick up the coverage on people who had left his employ.

Mr. SHARP. Well, does competition prevent you from doing that? What prevents you from doing that?

Mr. BIERSEBACH. If the only plan that we had available in the group area provided that we would have to cover the people who leave the group and convert to individual policies, our rates would be higher than those of group carriers who do not make that provision.

And, No. 2, very often a group coverage is a negotiated matter between the union and the employer and they dictate what benefits they want to provide, and that is not one that they want to provide.

Mr. SHARP. I would like to move on to a few final points, Mr. Chairman.

In 1967—I am sure the witness will recall, this subcommittee had credit life insurance hearings. In part 3 of those hearings, the Bank of America appeared here. Mr. Larkin of the Bank of America—now, it is our understanding, the please correct us if we are wrong—that Occidental carries a group accident and health case with the Bank of America, is that true?

Mr. BIERSEBACH. I believe that is true, yes.

Mr. SHARP. You do carry a group accident and health case. At that time, Mr. Larkin, representing the Bank of America, was talking about

a situation where the Prudential Life Insurance Co. was told by the Bank of America to reinsure part of the credit life insurance business back into Occidental and other carriers and at the time the subcommittee counsel was asking the Bank of America: "Why did you do this?"

And the Bank of America's Mr. Larkin went on to spell out:

The relationship between banks and insurance companies covers a wide range. They carry deposit balances with us. We, on the other hand, will sell off real estate loans to them. In fact, California, I would say, was built as much on money that was poured in by insurance companies, you might say foreign imports from the east and other States into California as was generated by our own savings and loans and banks.

He goes on:

So there are just a great variety of services that flow back and forth. And then, too, a bank as large as ours, with some 30,000 employees, has a number of insurance requirements, such as the benefits program of the bank. It covers many types of insurance, accident, casualty, loss insurance, all the things that a bank does with an insurance company. These create relationships between bank.

Then in response to a question by Mr. Cohen the chief counsel at the time: "Is the same true of Metropolitan and Occidental?" He asked about the relationship of the Bank of America with those companies.

Mr. Larkin responded:

Occidental probably is not quite as well off. But you will note in the schedule there that Occidental handles our study plan program and it was felt that they would make it up in this program . . .

Are you familiar with the so-called study plan program that the Occidental had with the Bank of America? What is this "study plan program"?

Mr. BIRSCHBACH. I honestly have never heard of the study plan program. It is a new one on me.

Mr. SHARP. Is that true of you, Mr. Frost?

Mr. FROST. That is true for me also, Mr. Sharp.

Mr. SHARP. In the annual statement of the Occidental Life Insurance Co. or 1971, there is a schedule listing non-interest-bearing bank deposits of the Occidental Insurance Co. in various banks.

And we note that, with the Bank of America, the Occidental on an average, for the year 1971, carried from \$8 million to \$9 million in interest-free demand deposits.

And yet, for example, with the Los Angeles, Calif., Western Bank & Trust Company, the average was perhaps \$200,000. With the United California Bank, the average came out to maybe \$400,000 or \$500,000, and that was it for the California banks.

Now, from a competitive standpoint, let us assume I am a smaller group accident health insurance company than Occidental, and I wish to do business with the Bank of America. I do not have the kind of assets that I could leave that kind of money in the Bank of America. How could I compete for the group accident and health business of the Bank of America? How could I compete against the Occidental?

Mr. BIRSCHBACH. Well, I really do not think that the assets that you could deposit in the Bank of America would have any effect on their decisions as to whether or not they are going to put their group benefits for sickness with you.

Mr. SHARP. According to what the Bank of America told us: "The relationship between banks and insurance companies covers a wide range. They carry deposit balances with us . . . so they are just a great variety of services that flow back and forth." Doesn't this indicate that, from the Bank of America's point of view, there is clearly established a relationship here. Do you have any comment?

Mr. FROST. Yes, I do, Mr. Sharp. You ran off a number of banks. The Bank of America is the main banking institution as far as Occidental Life Insurance Company. So the deposits would be larger. Whether the \$8 million is typical or not, I do not know. We could study that and find out.

I think perhaps one of the simplest, clearest examples we have, however, to the problem that you seem to be seeking here, or seeking the solution to.

The Bank of America competes, of course, with Occidental and other insurance companies for a retirement plan business. Their trust department competes directly with us and at the present time, Occidental is carrying part of their retirement plan business. We used to carry it all. We have given part of it back to their own trust department and they are engaging in probably what is one of the finest American things you can have, the plain old horserace as to who can do the best investment job—the investment analyst of Occidental, or the investment analyst of Bank of America's trust department. I am sure the bank and their employees will profit from it and I think that shows, more than anything else, the competitive relationship that exists between the two institutions in areas where we compete.

Mr. SHARP. I just have two more questions. Mr. Chairman, I think in fairness we ought to introduce into the record the bank schedule referred to of the Bank of America.

(Documents follow. Testimony resumes on p. 1112.)

ANNUAL STATEMENT FOR THE YEAR 1971 OF THE OCCIDENTAL LIFE INSURANCE COMPANY OF CALIFORNIA—SCHEDULE E¹

[Showing all Banks and Trust Companies in which an account was maintained at any time during the year, with balances, if any, at Dec. 31 of current year (according to company's records) and showing largest balance carried in each month of the current year in each bank or trust company in which the largest balance during the year exceeded 1/40 percent of admitted assets, Jan. 1, or \$500,000, whichever is smaller. (Any other items to be shown where required by statute.)]

(Give full name and location. State if bank is a parent, subsidiary, or affiliate.)	Bank or trust company ²	Balance Dec. 31 of current year	OPEN BANKS OR TRUST COMPANIES					
			January	February	March	April	May	June
DEPOSITORY ACCOUNTS ³								
Anchorage, Alaska: National Bank of Alaska.....		\$5,000.00						
Beverly Hills, Calif.: City National Bank.....		6,884.13						
Los Angeles, Calif.: Bank of America National Trust & Savings Association.....		3,376,679.84	\$9,880,194.07	\$9,857,214.36	\$8,470,677.54	\$7,263,291.75	\$6,895,147.59	\$11,463,516.45
Crocker-Citizens National Bank.....		52,942.18						
First Western Bank & Trust Co.....		64,037.18	242,883.07	375,660.25	748,746.50	273,675.91	273,515.11	276,338.68
United California Bank.....		—18,778.01	746,179.70	561,585.38	881,152.45	450,308.18	253,332.83	274,686.77
United California Bank.....		575,959.31	1,000.00	79,324.36	77,783.56	77,729.43	215,857.82	272,163.36
Security Pacific National Bank.....		54,256.30						
Sacramento, Calif.: United California Bank.....		5,448.70						
San Francisco, Calif.: Crocker-Citizens National Bank.....		68,760.95						
Honolulu, Hawaii: First Hawaiian Bank.....		92,632.09						
Chicago, Ill.: La Salle National Bank.....		8,130.63	657,986.07	574,240.95	405,612.75	512,766.64	709,616.20	572,295.96
Mercantile National Bank.....		28,562.25						
Des Moines, Iowa: Central National Bank & Trust Co.....		10,605.05						
Kansas City, Kans.: Brotherhood State Bank.....		7,251.58						
Anaconda, Mont.: First National Bank.....		13,724.90						
Butte, Mont.: First National Bank.....		15,398.68						
Cut Bank, Mont.: First National Bank of Cut Bank.....		2,942.81						
Eureka, Mont.: First National Bank of Eureka.....		13,241.91						
Glasgow, Mont.: First Security Bank of Glasgow.....		16,086.66						
Glendive, Mont.: First Security Bank of Glendive.....		5,030.52						
Helena, Mont.: Union Bank & Trust Co.....		45,589.07						
Miles City, Mont.: First Security Bank & Trust Co.....		7.16						
Missoula, Mont.: First National Bank of Missoula.....		23,565.73						
Whitefish, Mont.: First National Bank of Whitefish.....		5,150.81						
Minneapolis, Minn.: First National Bank.....		5,000.00						

Kansas City, Mo.: First National Bank.....	5,000.00	5,000.00	242,214.48	10,000.00	10,000.00	519,917.18	110,000.00
Albuquerque, N. Mex.: American Bank of Commerce New York, N.Y.: First National City Bank.....	6,001.94						
United States Trust Co.....	137,437.68	6,206,935.69	4,988,093.69	8,795,448.49	4,655,784.12	4,452,490.52	5,261,384.53
Fargo, N. Dak.: Fargo National Bank.....	150,000.00						
Cleveland, Ohio: Union Commerce Bank.....	10,193.18						
Portland, Oreg.: First National Bank.....	11,461.17						
Philadelphia, Pa.: Philadelphia National Bank.....	15,202.00						
Pittsburgh, Pa.: Pittsburgh National Bank.....	12,082.56						
Midland, Tex.: First National Bank.....	10,839.24						
Tacoma, Wash.: Pacific National Bank of Washington.....	10,140.34						
	182,952.51						
Total.....	5,035,391.05						

REVOLVING FUND ACCOUNTS

Birmingham, Ala.: First National Bank of Birmingham.....	358.51						
Anchorage, Alaska: National Bank of Alaska.....	1,357.35						
Tucson, Ariz.: First National Bank of Arizona.....	2,478.33						
Fresno, Calif.: Bank of America, National Trust & Savings Association.....	1,997.51						
Los Angeles, Calif.: Bank of America, National Trust & Savings Association, Occidental Center Branch, operations account.....	22,764.46						
Bank of America, National Trust & Savings Association, Occidental Center Branch, payroll account.....	2,041.09						
Bank of America, National Trust & Savings Association, Occidental Center Branch, agents' commission account.....	77,132.61						
Bank of America, National Trust & Savings Association, Occidental Center Branch, machine operation account.....	18,413.67						
Bank of America, National Trust & Savings Association, Occidental Center Branch, PAS operations account.....	1,000.00						
Bank of America, Occidental Center Branch.....	20,116.85						
Oakland, Calif.: United California Bank.....	1,914.74						
San Diego, Calif.: Bank of America, National Trust & Savings Association.....	1,938.39						
San Francisco, Calif.: Bank of America, National Trust & Savings Association.....	2,213.89						
Denver, Colo.: American National Bank.....	1,443.93						
Hartford, Conn.: Hartford National Bank & Trust Co.....	1,612.83						
Washington, D.C.: Riggs National Bank.....	1,931.45						

Footnotes on p. 1111.

Fargo, N. Dak.: Fargo National Bank
 Cleveland, Ohio: Union Commerce Bank
 Portland, Oreg.: First National Bank
 Philadelphia, Pa.: Philadelphia National Bank
 Pittsburgh, Pa.: Pittsburgh National Bank
 Midland, Tex.: First National Bank
 Tacoma, Wash.: Pacific National Bank of Washington

Total

REVOLVING FUND ACCOUNTS

Birmingham, Ala.: First National Bank of Birmingham
 Anchorage, Alaska: National Bank of Alaska
 Tucson, Ariz.: First National Bank of Arizona
 Fresno, Calif.: Bank of America, National Trust & Savings Association
 Los Angeles, Calif.: Bank of America, National Trust & Savings Association, Occidental Center Branch, operations account
 Bank of America, National Trust & Savings Association, Occidental Center Branch, payroll account
 Bank of America, National Trust & Savings Association, Occidental Center Branch, agents' commission account
 Bank of America, National Trust & Savings Association, Occidental Center Branch, machine operation account
 Bank of America, National Trust & Savings Association, Occidental Center Branch, PAS operations account
 Bank of America, Occidental Center Branch
 Oakland, Calif.: United California Bank
 San Diego, Calif.: Bank of America, National Trust & Savings Association
 San Francisco, Calif.: Bank of America, National Trust & Savings Association
 Denver, Colo.: American National Bank
 Hartford, Conn.: Hartford National Bank & Trust Co.
 Washington, D.C.: Riggs National Bank

¹ The figures in this table do not include separate account items if any.

² In each case where the depository is not an incorporated bank or trust company subject to governmental supervision, the word "PRIVATE" in capitals and in parentheses, thus—(PRIVATE), should

be inserted to the left of the name of the depository. Any deposit in suspended banks which is taken credit for should have a star placed opposite the amount in the schedule.

³ Average amount of interest received/accrued \$8,277,500.

Mr. SHARP. Now, in your statement, Mr. Bierschbach, you have said: "The element of competition under our economic system is, in our opinion, one of the most effective regulators of the business."

Perhaps we could agree that competition among the individual health insurance companies has stimulated a wide diversity of available policies, and there are some that feel that this is beneficial. Whether or not it is beneficial to the consumer is certainly debatable.

Now, with respect to the price of individual health insurance policies, it is difficult to understand how competition provides any meaningful regulation of premium charges when there is such a bewildering array of policies available, making comparisons almost impossible, except by the most sophisticated buyers.

Isn't this why a number of States have begun to regulate premiums on individual health policies in recent years?

Mr. BIRSCHBACH. I think I could quite easily explain, as an actuary, how competition affects and holds down the price of individual hospital coverages.

When I am setting the premium for an individual accident health insurance policy, I can make two mistakes. If I try to set it too high, the policy is not going to sell; and if I set it too low, I am more likely to lose my money.

So we have to be very careful and the primary force—I mean both on the open market and from our agencies division—would be to hold the premium down as low as possible so the policy would sell.

Mr. SHARP. But that means that the consumer must be able to compare the benefits offered with the price that is charged among the varying policies, and if you have a confusion of policies and benefits, it makes the consumers job very difficult and therefore doesn't it become self-defeating?

The less standardization you have, the more difficult it is to do price shopping—price comparison shopping. Isn't that a fact?

Mr. BIRSCHBACH. Well, in California, where we operate, there is a minimum benefit law, and we comply with the minimum benefit law.

That minimum benefit law is right now under study and the insurance commissioner is about to promulgate new regulations.

The variety of benefits that are available make it possible for the consumer to choose what it is he wants.

Mr. SHARP. Well let me ask you. The individual companies that have come before us, they have paid back, on the average, 50 cents out of every dollar with 50 cents usually being tied up in administrative costs, et cetera. If competition were working, how come this 50 cents has not been reduced all these years? We have made a study going back 20 years, and it has been about the same as far as dollars—not as to percentages, now—as far as dollars are concerned.

If competition has been working, why haven't these administrative costs been reduced?

Mr. BIRSCHBACH. Well, in our formal presentation, we pointed out the care that must be taken in interpreting the percentage of premiums that are paid out in the form of benefits.

And as I stated in my oral testimony and also my written testimony, Occidental last year paid out 62 percent.

Mr. SHARP. You have explained individual business, now, let's move on to group business.

In the group area, we could agree perhaps, that competition among group companies has tended to keep the administrative costs low so that they may now be between 5 and 10 cents of the premium dollar. But we have heard testimony that competition does not work with respect to the 90 cents or 95 cents or more paid out in benefits.

That there is really no price competition among doctors, and among hospitals and that the insurance companies are merely, as intermediaries, passing on the costs in rate increases. In the statistics and data that your company, for example, has submitted, they indicate numerous rate increases on group cases, and I think it should be pointed out that of the \$9 billion of commercial health insurance premium dollars in 1970, \$7 billion was group insurance.

The point here is competition just does not seem to be working with respect to the doctors and the hospitals and, in fact, it's driving up those costs.

All the insurance companies seem to be doing is passing the 90 to 95 cents off to the public, and the public, of course, here are the employers and the unions who are bargaining for the benefits. The taxpayers wind up paying half of this indirectly, a form of tax subsidization; and, the other half is being paid for in consumers in the price of the services and goods of the employer.

So just how are we to effectively control in this country these doctor and hospital service costs which you are passing on?

Mr. BIRSCHBACH. Well, your question goes to what we are doing to control costs more than the question about competition between group carriers.

Mr. SHARP. No; just how is competition working as to group insurance companies to control the underlying hospital and doctors provided costs. How is competition among insurance companies working to control the bulk of the dollar being passed on in rate increases? That is what I am trying to get at.

Mr. BIRSCHBACH. I don't know that it is competition that is doing it, but the insurance industry is taking steps to try to control the costs of providing coverage to the consumer.

In our written testimony, we pointed out that—not in our written testimony, in the material that was sent to you earlier in response to the first letter from the chairman. We pointed out that our claims examiners are trained to watch for excessive charges and for over utilization.

They are trained to do this and they are—if they detect a case of overcharge or over utilization, they will refer it to our medical department and see if our medical department agrees.

If the medical department agrees, we will go back to the provider and say, "You have overutilized the benefits. There have been excess charges." And then we refer them to a peer review group which will rule on the matter. So we are taking steps to try to hold down the costs.

I might also say that on the individual side, we do the same thing and right now there are two or three cases pending against us where we have gone back and said there is no justification, there has been overcharging, and there is one case where we have a \$2 million charge against us for punitive damages. But, nevertheless we are doing this, we are trying to overcome costs.

Mr. CHUMBS If Mr. Sharp; would—

Mr. SHARP. I have one question on this point here, is it all right, Mr. Chairman, to finish this one point?

Mr. Bierschbach, how many health insurance dollars do you pay out a year approximately? Do you have any idea?

Mr. BIRSCHBACH. Well, I have the 1971 annual statement with me and our benefit payments on accident and health policies, in the group, is for 1971, \$222 million plus; and in the individual area, it was \$10 million plus.

Mr. SHARP. You are paying out \$222 million approximately. Do you have any idea of the number of claims that those dollars represent?

Mr. BIRSCHBACH. I would not have any estimate as to that. I am sure, I could get that.

Mr. SHARP. Would you supply for the record the number of claims that these dollars represented in 1971, and the number of claims that your company has examined, both group and individual, from a cost standpoint to determine whether there was excessiveness in the underlying provider costs, broken down as to hospital and surgical.

Mr. BIRSCHBACH. We would be happy to do that.

(Documents follow. Testimony resumes on p. 1115.)

APPENDIX C

OCCIDENTAL LIFE OF CALIFORNIA,

June 21, 1972.

From: Policy Benefits Division.

To: Mr. Raymond A. Bierschbach,

Executive Vice President and Actuary.

Subject: 1971 Health Insurance Claims Paid.

During your testimony before the Senate Subcommittee on Antitrust and Monopoly, questions were asked regarding the number of claim payments made in 1971. The purpose of this memo is to supply the requested information. I will break the answer into two parts—Group and Individual.

GROUP HEALTH INSURANCE BENEFITS

The figure stated by you of "\$222 million plus" from the Annual Statement includes payment of claims on: Accidental Death, Dismemberment and Disability claims, reinsurance due on paid losses and other creditor disability insurance coverage as well as the claims relating to hospital and doctor charges. Eliminating kinds of claims not embraced by the inquiry to you leaves \$166,620,962 paid on claims relating to hospital and doctor charges.

Surveys show that hospital, surgical and medical care claims 1.2 drafts are issued per claim. Using this formula, it is estimated that the draft payments for medical coverage (1,510,707) relate to 1,258,923 claims.

All claims are carefully examined by trained examiners having as their aides Group Claim Instruction Manual, Medical dictionaries, guides and instructions for checking fee level and utilization appropriateness. Where there appears to be a charge in excess of that we usually encounter for the service rendered, or over-utilization of services or facilities, such claims are referred for special review by experienced physicians, dentists, registered nurses and other specialty technicians. In 1971 there were 19,329 referred for this special review; approximately 40 percent were reviewed for possible over-utilization.

Our record keeping, while responsive to our needs, does not make available a separation such as requested of you: "divided as to hospital and surgical". We have studied the mix of claims at our largest claim paying point and find the distribution to be:

	<i>Percent</i>
Hospital claims.....	16
Doctor charge claims.....	56
Dental services.....	18
Miscellaneous (drugs, blood, nursing, ambulance, appliances, etc.).....	10

Applying these figures to the estimated 1,258,923 claims processed in 1971, we conclude:

Kind	Percent	Number of claims
Hospital.....	16	201,420
Doctor.....	56	704,990
Dentist.....	18	226,600
Miscellaneous.....	10	125,890

And, of the 1,133,000 claims involving hospital charges and doctor and dentists charges we screened all on the topics of usual and customary fees and/or utilization: special review was warranted on 19,329 of these claims.

INDIVIDUAL HEALTH INSURANCE

A total of \$10,250,058 of benefits was paid out on Individual Health insurance. Of this, \$7,430,412 was paid on medical expense type policies. The following remarks relate to that type of claim.

There were 11,946 registered claims with an average pay-out of \$622 for each claim. All claims were carefully screened by experienced examiners who are equipped with a claim manual and a complete set of reference books. When we had occasion to question a claim it was referred to the Medical Department where we were given professional advice regarding excessive charges and over-utilization. Since we keep no central records of Medical Department reviews, we cannot furnish a figure showing how many of these claims were so reviewed.

Since we insure only necessary medical expenses our scrutiny in the field of utilization of services has generated some conflict with providers and insureds. These conflicts are usually resolved with the help of the appropriate component medical or hospital association facilities for local Peer Review. Occasionally, litigation has been involved with punitive damages sought by the Plaintiff. And, intervention of the appropriate Insurance Department has aided us in disposing of some of these controversies.

In Individual Health, since the only dentistry we pay is that occasioned by an accidental injury, there is no significant figure available.

C. DONALD HANKIN,
Senior Vice President.

Mr. SHARP. Thank you.

Mr. CHUMBRIS. Thank you, Mr. Sharp. Well, since Mr. Sharp went off on that point, there is no use in me belaboring the record. But the record will show that Mr. Woodcock testified that he was concerned, and so were a lot of other people, that his union people had their group health insurance increase 132 percent in 5 years; when the record also shows—because I had a colloquy with Mr. Woodcock on that—to point out that in 1965, the per patient cost in a hospital was only \$46 a day and it went up to \$92 a day, when we had our hearings in 1970; and as I understand it now, it is almost \$107 a day.

So naturally the costs have gone up, the hospital costs not including the medical costs, and so forth, so I would assume, if you are paying out those bills, there comes a time—and it has more than doubled—there comes a time when you are going to have to increase your premium. There is no other way out, is there?

Mr. BIRSCHBACH. No, sir.

Mr. CHUMBRIS. Whether you are a commercial insurer or whether you are Blue Cross or whether you are an HMO outfit, it would not make any difference. And I think that one of the purposes of those hearings back in 1969 and 1970 was to try to see how we could squeeze across from the \$92 a day that you had as a per patient cost in the Washington Hospital as you could possibly squeeze across out of that to get back to a level where the costs might get—I know you will never get back to \$46 a day basis, but if you could just squeeze the costs somehow. But as long as those costs are going to go up and you

expect your bills to be paid by the insurer, the insurer is going to have to receive a premium commensurate with the cost he is going to pay on it. Is that right?

Mr. BIRSCHBACH. That is correct.

Mr. CHUMBRIS. That is the only way you can do business?

Mr. BIRSCHBACH. Yes, sir.

Mr. CHUMBRIS. That is the only way we can operate, too. We have a budget here of some \$600-and-some-thousand and we are wondering whether we can survive the full year because of the additional costs that have been placed upon our subcommittee by Congress passing an increase in wages.

And so we have to figure out how we can live within that \$600-and-some-thousand, and if we don't live within it, at the end of the—in December or January, there might be one month where nobody is going to get paid.

I have no further questions, Mr. Chairman. I think we have kept Mr. Amos waiting a little bit too long already.

Senator HART. Thank you very much.

(Documents relating to Mr. Bierschbach's testimony follow. Testimony resumes on p. 1118.)

OCCIDENTAL LIFE INSURANCE COMPANY OF CALIFORNIA,

March 17, 1970.

ALL MANAGERS IN CHARGE OF SEPARATE GROUP OFFICES

Subject: Select Risk Underwriting (Confidential).

This bulletin and attachment replace the previous editions of 514, 514.1 and the Select Risk Underwriting form GMM-1812 which should be removed from your binder and destroyed. The Underwriting Guide attached to 514 should be retained with the current bulletin. 514.1 is obsolete. The Table of Contents should be updated to reflect this. The major change is in the conditions for discounting.

Regional Group Managers are authorized to discount H&S and Major Medical rates under the following conditions:

1. Employer-employee type cases only, in which no legal problems are involved, such as lives in New York.

2. Variable type plans with a combined total annual premium of less than \$25,000 or not more than 100 lives.

3. Benefits and risk must conform to the Group manual.

4. The Regional Group Manager must personally recommend the group as a select risk and state the reasons why he feels this is a better than average case. Select Risk Underwriting, form GMM-1812, (copy attached) indicating the discount used and the reasons for the discount, must accompany a copy of each proposal.

5. No first year commission of 20% and 5% graded.

Select Risk discounts may be allowed up to 10%.

On select business, including a take-over case, the Regional Group Manager is authorized to issue a proposal without prior Home Office approval of the rate basis. The Home Office underwriter will not re-underwrite cases recommended for a special discount by the Regional Group Manager, and will be bound by the rates quoted, except in the case of substantial mathematical error. A properly licensed agent must have been appointed at the time the application is taken. Each proposal must be checked for accuracy and verified by some qualified person in the office other than the one who made the original calculation.

The Underwriting Guide should be used as an aid to underwriting the more favorable risks. These guide lines should be reviewed each time consideration is being given for the special discount.

Full responsibility for taking select risk discounts is vested in the Regional Group Manager. If a Regional Group Manager does not exercise proper judgment and/or abuses the select risk privilege, it may be withdrawn.

The current edition of the Select Risk Underwriting Form GMM-1812 should be ordered on your regular monthly supply requisition Form SB. Upon receipt of this order, destroy your existing supply of the previous edition.

Attachment.

Office _____ Code _____

Regional Group Manager's Evaluation of Empolyer Prospects with less than \$25,000 combined annual premium or with less than 100 lives.

Submit *Signed* to Director of group sales upon releasing a proposal together with:

1. GMM-1592, and required underwriting forms, and
2. Copy of proposal's benefit and cost pages, listing proposal pages used.

Name of prospect _____

Why is case out to bid (if takeover) _____

Select risk discounts used: _____

Emp. H	Dep. H	Emp. X	Dep. X
Reasons: _____			

Regional Group Manager					Date
Coverage	Gross manual rate	Factor for volume discount	Manual rate after discount (1) × (2)	90percent of (3)	Rate quoted
	(1)	(2)	(3)	(4)	(5)
Life				XXXXXX	
AD & D				XXXXXX	
A & S				XXXXXX	
Hosp-Emp					
Hosp-Dep					
MM-X-Emp					
MM-X-Dep					

ALL GROUP FIELD MEN

JULY 30, 1970.

Subject: Miscarriage Benefit.

All policies effective August 1, 1970 and later with maternity benefits, will limit the miscarriage benefit (*which would include abortion—either voluntary or involuntary*) to one half of the dollar amount provided for normal maternity.

Group Sales offices will be contacted by Group Underwriting, regarding the endorsement of this limitation into all current policies having a flat pregnancy benefit in excess of \$200. Most of these policies are under our 10-Plus groups.

POST-CLAIM UNDERWRITING

During the processing of claims, we may encounter certain information about the insured that affects the risk involved in the contract. This information may range from past health history, unknown at the time of underwriting the application, to changes in occupation or health, since the policy was issued. As soon as the information is discovered, the underwriting referral box on the face sheet should be marked for referral. In this manner, the possibility of overlooking the pertinent information, when closing out the claim, is avoided.

The referral to underwriters permits the information learned during the handling of the claim to be coded and made available to other insurance companies through the inter-business information bureaus. At the same time, our underwriters can be made aware of any changes in the risk insured. This is important even though many currently issued policies are guaranteed renewable, as this information will be of importance in the event the policy lapses and application is made for reinstatement.

Generally speaking, any medical information that indicates a material change in the health of the insured or covered members that has not previously been

brought to the attention of the underwriters, should be referred for post-claim review. Any change in occupation or any moral hazard that is discovered that would affect the potential liability of the policy, should be referred to the underwriters.

When in doubt about referring, ask yourself, "Would it be in the best interest of the Company to insure the individual with this policy in light of this new information?" If the answer is "No", refer the file. If you are still in doubt, refer the file anyway.

The file is routed for post-claim underwriting by checking the "Yes" box on the face sheet under the heading, "Refer to Underwriters." If you have a specific recommendation for the underwriters to consider, such as to review or to discontinue the policy, place those words in the recommendation blank.

When the claim is completed and to be closed out, recheck your referral decision and recommendations, to see if they are still appropriate. If so, close the claim in the usual manner and the Clerk at the close-out desk will note the desired handling and will refer the file to the Underwriting Department.

Senator HART. Our next witness will be the chairman of the board and president of American Family Life Assurance Co. of Columbus, Ga., Mr. John B. Amos.

STATEMENT OF JOHN B. AMOS, PRESIDENT, AMERICAN FAMILY LIFE ASSURANCE CO.

Mr. Amos. Mr. Chairman, I am not going to attempt to read in full the report or paper that I submitted.

Senator HART. It will be printed in the record.

(The document follows. Testimony resumes on p. 1143.)

STATEMENT OF JOHN B. AMOS, PRESIDENT, AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS, COLUMBUS, GA., BEFORE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY OF THE U.S. SENATE, JUNE 7, 1972

MR. CHAIRMAN, MEMBERS OF THE SENATE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY:

My name is John B. Amos. I am president of the American Family Life Assurance Company of Columbus, Georgia and I am grateful for the opportunity to appear before you today. I wish to acquaint you with some of the antisocial effects of "COB", the coordination of benefits clause found in most group accident and health policies and so highly praised by Mr. Johnson of Aetna. I also wish to defend my Company against a knowingly false and reckless charge made by Mr. Denenberg, the Pennsylvania Insurance Commissioner, before this Committee and in explanation of his testimony when talking to the press.

I have with me Malcolm A. Hoffmann, Counsel of the Company. Mr. Hoffmann's law firm represents my Company in two litigations pending in the Federal Courts of Georgia and Florida. These cases charge that "COB" operates as a boycott against us.

My company, American Family Life, sells insurance against medical and hospital expenses resulting from cancer. We also sell a token amount of life insurance and other accident and health policies. We sell our Cancer Plan policy in 42 states, the District of Columbia, the Commonwealth of Puerto Rico and the United Kingdom.

During fourteen years of writing cancer policies we have grown from a tiny company, based in Georgia, to the tenth largest writer of individual non-cancellable accident and health insurance. We sell cancer insurance only to supplement other medical risk insurance policies and we sell it because most of our subscribers wish peace of mind against the high probability that the insured or a member of his family will contract cancer.

We believe in the free enterprise system and we believe that the insurance industry should be part of it.

We believe that these hearings would have been unnecessary had free competition prevailed in the insurance market. The free enterprise system has an innate way of fulfilling a need at a price the customer can afford to pay.

We do not understand how such an important service to the society as medical insurance can be removed from the competitive forces which tend to improve the quality and lower the price of insurance. That is not to say that we are opposed to regulation in the interest of fairness to all concerned. We do, however, believe that some of the practices used by major medical insurers and Blue Cross/Blue Shield run counter to the interests of the buying public and constitute violations of the antitrust laws as I expect to demonstrate in the course of this statement.

American Family Life Assurance Company of Columbus, Georgia, is a small company in comparison with the handful of giants writing medical care policies; for example, our assets are currently about \$21 million. 80% of our business in force is represented by our Cancer Plan policies which cover solely the separate risk of cancer. We presently have about 850,000 Cancer Plan policy holders and we are growing rapidly. These policies bring a sense of security to persons who face up to the fact that cancer is the second largest cause of death among all diseases in this country. I said that we afford security against this killer but we, by no means, can fully offset its terrible economic effects upon a family and do not purport to do so.

Broad based insurance coverage is generally believed to be intended to cover all medical expenses. This is not necessarily so. Blue Cross/Blue Shield is the largest writer of this insurance and this Committee is familiar with its group approach. However, group medical care insurance often has notable exceptions and limitations. Blue Cross, for example, does not generally cover charges for blood. Commercial carriers usually exclude certain expenses associated with mental illness. Surgical procedures if performed in a physician's office may not be covered. "Allowable Expenses" are truly only what the carriers consider to be allowable.

While group major medical and other broad base coverage is intended to protect against large expenses associated with all types of medical problems, as a real life matter, that is a theoretical objective only, because as in the case of life insurance, a person may be covered for \$1,000 or for \$100,000. The levels of group medical care insurance can range from inadequate to seldom adequate.

Writers of special risk insurance, such as ourselves, cannot compete with the carriers selling a broad based coverage although broad base policies necessarily compete with the special risk insurers. The special medical risk is included ordinarily among the risks covered on the broad based insurance. To the extent that the broad base insurance contains, as it almost always does, COB provisions about which I will comment later, the COB provisions, when applied, eliminate the utility of special risk policies. But we have no desire to substitute our policy for broad risk and, of course, never sell it in this way.

Let me be equally emphatic in stating that special risk insurance, such as cancer insurance, is not a substitute for broad base coverage; it is solely a supplement. In no case do we believe that it is reasonably possible for cancer insurance to be misrepresented as broad base coverage.

WHY DO PEOPLE BUY SPECIAL RISK INSURANCE

Special risk insurance has been around since the beginning of insurance time. The giant Travelers Insurance Company started by writing accident insurance, with health policies entering the scene in 1899. Airline trip insurance is but an extension of safe voyage insurance of the hazardous sea faring days. Double indemnity is a very prevalent special risk insurance coverage which pays only upon accidental death. Dread disease supplements have been available as a Blue Cross optional coverage rider for many years. Polio insurance was commonplace in the pre-Salk Vaccine days. It parallels the concern of the times. Today cancer insurance is becoming prevalent; it reflects the public's concern about cancer. They are buying peace of mind through extra coverage.

ARROGANCE OF INSURANCE COMPANIES

The broad based medical insurance carriers claim that there is a virtue in the proposition that the hurt and sick should be paid only to the extent that they (the carriers) consider "Allowable Expenses". This principal is subsumed under the phrase "100% reimbursement". In their actuarial calculations they list as 100% reimbursement the payment of hospital, doctors and medical bills as specifically defined in their broad risk policies. They often assert that 80% of that covered risk is an optimum point beyond which carriers ought not to go. Some

of these pat phrases of the insurance industry ought to be analyzed by this Committee.

First, the justification for not paying more than 100% of accident and health policy designated risk is said to be that "over insurance" is bad. Health insurance Association of America and other insurance associations claim that "over insurance" will induce malingering and sloppy hospital administration with such consequences as unnecessary diathermy treatment, unnecessary diagnostic measures, etc. The carriers say they must also prevent doctors from sending patients unnecessarily to hospitals and keeping them in hospital beds too long. Implied in this justification for limiting insurance is that the insurance company managers have higher standards and better morals than hospital administrators and licensed physicians together with more knowledge as to the management of hospitals and the proper behavior of physicians.

I have read the testimony of Mr. Denenberg, the Insurance Commissioner of Pennsylvania, before this Committee and he went so far as to suggest that an insurance company claim clerk by looking at doctor's records can determine, after the event, whether or not an operation was justified. A doctor's record, he asserts, will establish whether the doctor was prone to unnecessary surgery. Mr. Denenberg concludes that after such a check of a doctor his patient should be denied payment of his claims and offered the alternative of suing the doctor for malpractice. This point of view reflects the extraordinary arrogance of the insurance industry generally, and this Insurance Commissioner in particular.

There is no magic in the "100%" as a guide for compensation. First, what is meant is the abstract 100% payment to the insured of precisely the specific medical expenses as defined in the sickness and health policy. Those medical expenses do not cover the full spectrum of medical expenses. I have never examined a policy which did. A hurried trip to the hospital in a taxi-cab, the need to bring a mother by airplane to the bedside, the need for immediate non-medical assistance or substitution is not covered. There are many risks associated with accident and sickness which are just as real and just as important as the risks covered on the face of the policy which are never covered by the policies.

Secondly, there has never been a demonstration made by the insurance industry that so-called "over insurance" is a real social problem.

At one time the Health Insurance Association of America made a study of a hospital in order to determine whether the length of time spent in bed could be correlated with multiple insurance policies; the result demonstrated just the opposite, and although the study has been misleadingly used we have not been able to find any other studies of this kind being made. "Over insurance" is an invention of the insurance industry in an effort to reduce benefits paid to people who are ill. My general impression is that doctors are much maligned and that they constitute a decent hard-working profession which has no need to engage in fraud or chicanery. Indeed, in most of the United States the doctors have a real problem in finding hospital beds for their sick patients and would be more inclined to remove a patient from a bed quickly than leave him there unnecessarily. I am not qualified to comment on whether or not their fees should be regulated. Hospital administrators are not in the business of selling diathermy treatments, or unnecessary x-rays, and have no incentive for doing so when their hospitals are full and behind them are long waiting lists of people who have real need for hospital facilities.

The entire justification for this concept of single insurance is a myth and a libel. The justification becomes particularly absurd when it is applied against a patient suffering from cancer. Cancer, in its more mordant form, is a sure killer and presages a long, painful illness. There are precise diagnostic techniques of scientific nature which indicate the presence or absence of cancer. Its symptoms are of such involuntary character that they cannot be artificially simulated. Consequently, any notion that public policy requires a single payment to cancer patients is both cruel and absurd.

A real risk which the cancer patient experiences, beyond his pain and the prospect of an early death, is the destruction of his family, his position in society and the enormous burden he becomes as his illness progressively renders him less able to perform his life's functions. No number of policies or any amount of money can compensate the cancer patient for this tragedy. There is nothing in these policies which covers loss of income, increased travel expenses, loss of relative's time from employment, the unusual changes in family life necessary to cater to the terribly ill or dying patient and at best the principle is an abstract principle which has no support in reality.

Had overinsurance really been a problem it could have been easily cured by underwriting and declining to insure a person who already had coverage. The fact is the carriers like to sell overinsurance. They like to collect premiums on policies they will never have to pay claims upon because of the COB provision. That is the crux of the thing.

You may, within some limitation, buy as much travel insurance as you want notwithstanding that you might blow up an airplane to get the benefits. You may write as many policies on your life as you want, given insurability and ability to pay, notwithstanding the circumstance that you may openly or secretly commit suicide. The insurance companies protect themselves against these possibilities by fixing their own rates which include the risk of airplane destruction and suicide as premium factors. There certainly exists no more reason for allowing multiple policies on life than on health.

COORDINATION OF BENEFITS PROVISION ("COB")

The Coordination of Benefits provision was formulated as a result of joint action among the carriers and through their trade associations and was worked out in detail in a Model form which the associations recommended to the industry near the end of 1962. It was not then and never has been sanctioned by the National Association of Insurance Commissioners. Thereafter, a COB provision, either in the precise recommended or similar form, was adopted by almost the entire medical insurance industry. The Coordination of Benefits provision, or "COB" as it has become known, provides for confiscation by insurance carriers of sums otherwise payable to sick or injured insureds by other insurance companies on policies for which a full premium has been paid. The very designation "coordination of benefits" was adopted for the admitted purpose of confusing the public. The term "reduction of benefits" would have been more descriptive and appropriate. The coordination of benefits works in this way. If an insured under a group medical plan is also an insured under another group medical plan as the dependent on a working spouse's policy, an order of priority is spelled out. Where the husband works for General Motors and receives as part of his compensation medical coverage for himself and his family, and the wife works at Ford and receives as part of her compensation medical coverage for herself and her family, and a claim arises on the husband, General Motors' carrier would pay all of the "Allowable Expenses" under its policy before any call would be made upon Ford's carrier. Ford's carrier would pay any difference between the "Allowable Expenses" under the General Motors policy and the "Allowable Expenses" under its own policy. As an example, if the surgeon's fee were \$500 and the allowable sum under the General Motors policy were \$300 and under the Ford policy \$400, Ford's carrier would be called upon to pay \$100, not the full difference between the surgeon's bill and the \$300 paid by General Motors' carrier. If the wife is the claimant, Ford's carrier would go first and General Motors' carrier would go excess to its allowable limits. A child of the couple would be primarily charged to the Father's carrier, with the Mother's carrier picking up excess.

But, in order to whip the industry into line and force the adoption of the "COB" provision, one other provision was added. It is termed the "dumping clause". It provides that in the event one or the other policy does not contain a coordination of benefit provisions, then that policy shall be primary payer in all instances, and the policy containing the provision will only be excess to the extent of its allowable limits.

The carriers agree to exchange information and to cooperate in policing the payment of claims to the extent necessary to reduce the benefits each shall pay out.

In the above illustration, should either the husband or the wife buy a cancer policy from us on any group arrangement, whatever sum we paid on a cancer claim would be deducted in toto from any sum that the basic group carrier or carriers would be otherwise obligated to pay, and the insurance which they purchased from us and paid for out of their own hard earned money would return them not one cent. Thus, it can be seen that they are coerced and intimidated into not subscribing to our plan, and we have been boycotted and a market closed to us.

This curtailment of benefits is said to have been designated to eliminate what the Associations have sometimes referred to as "profit" to the insured, for example, his profit on cancer. See "Report of the Health Insurance Association of Amer-

ica", Nov. 30, 1961, page 8, and see also the "Second Report" of the insurance association, dated Dec. 10, 1962, and containing the precise form of suggested Model COB provision. These documents are attached to my statements, as Exhibits A and B respectively.

In my opinion the COB provision is a handy gimmick to reduce expectable benefits where multiple policies exist and to swell the revenues of private medical carriers and their employer customers.

It is estimated that the insurance industry by the use of coordination of benefits deprives insureds throughout the country of a total in excess of \$100,000,000 each year in benefits for which a full premium has been paid either by the insured or on his behalf and as a part of his compensation by his employer. Blue Cross of Florida alone "saved" \$5,000,000 last year and Aetna, according to the testimony of Mr. Johnson before this Committee, "saved" over \$15,000,000. It could well be that since the beginning of "COB" insureds have been deprived of over a billion dollars of monies to which they were entitled.

It is interesting to note that Blue Cross/Blue Shield did not originally go along with the COB provision but were subsequently forced into using it as a result of being "Cobbed" against. They referred to it time and again as a "dumping clause" which dumped all the claims of commercial carriers on them first, permitting the commercial carriers to pick up only any claims residues.

Speaking of the non-competitive medical insurance industry, Mr. Woodcock said in his testimony on May 10, 1972: "However, this competition is controlled by a small group of giant companies. Ten giant health insurance companies write 60 percent of the total group health business rounded up by the commercial industry. And these dictate the rules of the game to the rest."

COB has damaged my company's possibilities in writing policies and has excluded me from many places. American Family Life sells much of its cancer insurance on a franchise basis. Franchise insurance is individual insurance, sold to employees of an employer as a unit, but underwritten individually. As we have seen, part of COB is a "dumping clause" providing that companies whose policies do not contain COB must always pay first. We do not and cannot participate in coordination of benefits. When one of our claimants is covered by both our insurance and by a broad risk health insurance policy, as we believe he ought to be, we are the only company to pay him unless his expenses exceed the limits of our policy. The broad risk company refuses to pay even though it has accepted and invested a premium. The employee then discovers that he has received only one benefit for two premiums. The consequence to us has been that in some instances employees have chosen to drop our insurance, and, often, employers decline to cooperate with us in premium deductions.

We are boycotted by COB which always makes us the primary payor. Two lawsuits, one in Georgia and one in Florida, in the Federal Courts, are designed to give us relief from this boycott. Mr. Hoffman is available to answer any questions you may have concerning these cases.

Gentlemen, these lawsuits depend on Section 3(b) of the McCarran-Ferguson Act which outlaws boycott, coercion and intimidation at the hands of insurance companies. But, as this Committee well knows, insurance companies are otherwise exempt from operation of the antitrust laws when a particular restraint is under regulation by the state. That exemption may have been the biggest and most selfish power grab of the century.

Not ourselves alone but all writers of special medical insurance are subject to boycott to the extent that the broad based carriers wish to COB against them. Blue Cross and Blue Shield, in the State of Florida, have asserted the right to COB against our cancer policy even when it is written on an individual door-to-door basis. Cob is self-enforcing. The "dumping clause" of COB not only prevents the claimant from receiving the two benefits for which he has paid, but it also increases the expenses of companies not using COB above the level of those companies using COB, since the former must always pay. For this reason many companies have adopted COB who otherwise might not have. This was intended as the enforcement provision. Either join the system or get out of the health insurance field. Like the "Godfather" they make a proposition you can't afford to turn down. Not even Blue Cross could reject the proposition. No company can afford to be in the position of always paying first, and still compete with the others. Thus, the boycott is enforced by economic coercion, and most carriers who stay in the health insurance field are forced to join the conspiracy.

It is believed that at least 95% of all group medical insurance now written contains a COB provision.

MISLEADING REPRESENTATIONS OF MR. DENENBERG

Gentlemen, Mr. Denenberg, the Commissioner of Insurance for Pennsylvania came before this Committee and made charges involving my company which I consider to be both false and knowingly misleading.

At page 296 of the Transcript of his testimony he spoke of cancer insurance and other dread disease policies saying, "They can be marketed at what seems to be a low premium, because it is geared to return only a small percentage of premiums in benefits." Later, at page 307 of the Transcript, he said, ". . . we have a company in Pennsylvania selling cancer insurance that is returning 7 cents on the premium dollar, and, as I say, you can do better with the Pennsylvania lottery that returns 45 percent, which is better than auto insurance, and very close to being as good as individual health insurance." Finally, in talking to the press he did not hesitate to identify the company referred to in this way as the American Family Life Insurance Company, of which I am president.

This Committee will understand that we do not write cancer insurance to people who have cancer at the time when they apply for our policy. We write our insurance for anyone else. It is not to be expected that in the first few years of the policy's life the insured will contract cancer. We have only done business in Pennsylvania since July 1970. I emphasize this circumstance because we had been selling policies in that State for the very short period of 19 months at the close of business, December 31, 1971. Of course, we have only paid out 7% on claims in this short period.

Beginning our sales effort in Pennsylvania only in June of 1970, we issued only 1,712 policies during the entire year. It is logical to assume that most of these policies were issued in the last quarter and subject to a 120 day waiting period. We issued 6,226 policies in 1971, and it is also logical to assume that most of these were issued in the last part of the year, because in the production of new business there is a spiral effect. You have to sell the first policy before you can sell the next two, and you have to sell the first 10 before you can sell the next 20—the next 20 coming much easier than the first 10. We therefore must conclude that because of the waiting period our exposure in Pennsylvania during the years 1970 and 1971 was at a minimum.

The average age at the time of issuance of our policy is age 47, while the average age at the time a claim is first submitted is age 60. We have monitored various blocks of cancer business over the years and they have aggregate loss ratios ranging from 30% to as high as 88%, the higher ratio being associated with the older business.

We have experienced loss ratios by policy years as follows :

Policy year and percent of loss ratio

1	-----	16
2	-----	30
3	-----	36
4	-----	42
6	-----	¹ 50
8	-----	¹ 60
10	-----	¹ 70

¹ Projection based on experience to date of rather small blocks of cancer business issued in the beginning of the company's cancer insurance sales activities.

Mr. Denenberg, a self-proclaimed insurance expert whose total experience has been confined to the classroom and consultation, could not have failed to realize that there could be no meaningful payout experience in the Commonwealth of Pennsylvania until at least six or eight years have elapsed. We, however, must set aside a reserve for the payment of claims and we do this on a proper actuarial basis. More significant than anything that Mr. Denenberg may say concerning our policy is the approval of our policyholders themselves who, for the most part, do not permit our policy to lapse even though it is written on a yearly basis; they carry it through the time period when cancer is most likely to strike, and have every opportunity to learn whether or not it is worthwhile coverage.

The lapse rates of all our cancer business in force are as follows :

Policy year and percent of policies lapsing in policy year

1	-----	20
2	-----	15
3	-----	12
4	-----	10
5	-----	8
6 and thereafter	-----	7

Mr. Denenberg may be disturbed that the Courts of Pennsylvania overturned his administrative ruling barring the sale of cancer insurance in Pennsylvania, but I see no need to go any further in defending ourselves against the charges of a man who stated in answer to Senator Gurney's question, "The insurance companies will make a decision as to whether that appendectomy was done properly or not." (Transcript, page 341).

So much for Mr. Denenberg.

RECOMMENDATIONS

It is my belief that the free enterprise system carries within itself its own seeds of destruction. Left to its own devices and free of all restraints it will destroy itself. It will freely fix prices, freely monopolize, freely boycott, freely destroy competition to the point that it is no longer free enterprise but controlled enterprise—controlled by the greedy and selfish few, turning out an inferior product at the highest cost the traffic will bear.

American industry was closely approaching that point around the turn of the century when Congress enacted the Antitrust Laws. Yet the largest industry in the country, dwarfing all other industries and combinations of giant industries, has been exempt from the protection of the Antitrust Laws, except in the limited case of boycott, coercion and intimidation. I use the word protection because in the absence of the Antitrust Laws free enterprise would be a phrase foreign to the people of the United States in this year 1972.

I truly believe that we are faced with a health insurance crisis today because competition in the insurance industry does not exist. Yes, it exists at the local agent level, but at the top it is one big, happy family run solely for its own good by countless committees of over 200 insurance trade associations.

This industry, controlling assets in total approaching the size of the national debt of the United States, has the power to control the stock markets, to buy control of any industry, even to manipulate and fix the price of gold. It cannot be allowed longer the absolute freedom that it enjoys outside the Antitrust Laws. It must not be allowed freedom to destroy itself as it apparently is doing in the health insurance field.

In closing, I recommend to this Committee that it give serious consideration to the question of whether or not the insurance exemption embodied in the McCarren-Ferguson Act should be repealed by the Congress so that insurance companies are subject to the "Magna Charta" of free enterprise which is embodied in the Sherman and Clayton Acts. Their constant exchange of competitive information taking place in endless meetings, their joint activities expressed through hundreds of trade associations, their joint representations to commissions and governmental bodies as the end products of all agreements, all suggest that the insurance companies continually conspire together for their own benefit and to the disadvantage of the policyholders and the economy at large.

I also suggest that this subcommittee call for the records of the insurance companies concerning the coordination of benefits provision, and we shall be glad to cooperate in such an investigation. I believe that the Commission will learn that overinsurance as related to the use of COB is sheer pretext, and that the real purpose of COB is to reduce the payments to sick people holding policies.

Forced to compete, in the truest sense of the word, in the marketplace, the insurance industry of this Nation can and would rise to the occasion and provide fully for the health insurance needs of the population at a price the public would be willing and could afford to pay.

I thank you, gentlemen, for your time.

JOHN B. AMOS,

*President and Chairman of the Board,
American Family Life Assurance Company of Columbus, Ga.*

EXHIBITS A AND B TO THE STATEMENT OF JOHN B. AMOS, PRESIDENT, AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS, COLUMBUS, GA., BEFORE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY OF THE U.S. SENATE, JUNE 7, 1972

HEALTH INSURANCE ASSOCIATION OF AMERICA,
Chicago, Ill., November 30, 1961.

GROUP HEALTH INSURANCE ASPECTS OF OVERINSURANCE AGAINST HOSPITAL,
SURGICAL, AND MEDICAL EXPENSES

Attached to this bulletin, for the information and guidance of member companies, is a study entitled "Group Health Insurance Viewpoints on Overinsurance" which has been prepared by a Joint ALC-HIAA-LIAA "Study Group" appointed to research the group health insurance aspects of overinsurance. This study has been concurred in by appropriate committees—in the case of the HIAA, by the Committee on Economics of Financing Medical Care and its Subcommittee on Overinsurance—with a request that this general distribution of the study be made.

This study of health overinsurance as it affects the group coverages is timely for several reasons. The health insurance business has been under criticism from physicians and other health service providers for creating a financial incentive, through overinsurance, for hospital patients to try to stretch their stays in order to enhance the profit from overinsurance. Also, the health overinsurance problem in the individual policy field is presently under scrutiny by the National Association of Insurance Commissioners, although primarily in terms of what amendments are needed in the Uniform Individual Accident and Sickness Policy Provisions Law to allow companies to include effective clauses in their individual policies to counteract the wasteful aspects of overinsurance on claim costs. Group Health insurance policies, not being subject to such uniform policy provision requirements, will not be directly affected by the outcome of the individual policy proposals now before the NAIC, but may be indirectly affected.

Among other matters, the Study Group explored such issues as what "other valid coverages" should be taken into account in providing for reduced claim payments to prevent a claimant from making a profit from overlapping health insurance protection, when such a profit shall be deemed to have occurred with respect to a claimant having both insured and uninsured expenses, and how insurance benefits might appropriately be cut back, by policy provision, when the combined claim payments would otherwise produce a profit to the claimant.

Additional copies of the attached study are available on request. This matter of health overinsurance in the group field will continue to receive the attention of committees of the three Associations, so that the current study may be regarded as a "progress report". It is not anticipated, however, that a further release of this type will be made until after further NAIC consideration of the corresponding individual policy aspects of this issue has taken place and a possible course of action has taken tentative form.

This bulletin is also being sent to persons who receive HIAA Insurance Department Bulletins, the Committee on Economics of Financing Medical Care and its Overinsurance Subcommittee and Group Task Force and Individual Task Force, the Group Insurance Committee, Individual Insurance Committee, and Legislative Committee.

GROUP HEALTH INSURANCE VIEWPOINTS ON OVERINSURANCE

CONCLUSIONS

In preparing this paper the Study Group on Non-Duplication of Accident and Health Insurance Benefits reached certain conclusions which are set forth below with the hope that they will be of some help to those who must make policy decisions with respect to the solution of the overinsurance problem.

(1) APPROACH

No single approach in use today seems perfect. It would appear that much work needs to be done to make anti-duplication provisions more practical and economical to administer and more acceptable to the insuring public.

(2) OTHER VALID COVERAGE

The Study Group was divided as to whether other valid coverage should be limited to Group and Governmental plans or should be unrestricted so that each carrier would have the right to define Other Valid Coverage in as broad a fashion as the carrier deemed practical. There was general agreement, however, that the third party liability payments should be handled, if at all, by a special subrogation provision rather than by inclusion in the definition of Other Valid Coverage.

(3) EXPENSE BASIS FOR MEASURING OVERINSURANCE

After due consideration of the rights of the public, the Group policyholders and the insurance carriers, a majority of the Study Group feels that overinsurance should be measured on the "total expense basis," (that is, no compartmentalization) and that the definition of allowable expense should be "any necessary, reasonable, and customary expense, all or part of which is a covered medical expense under at least one of the plans involved." The minority feels that compartmentalization of all hospital expenses from all other expenses should be permissible and that allowable expenses might be limited solely to the covered medical expenses of one's own plan.

(4) TIME BASIS FOR MEASURING OVERINSURANCE

The Study Group recommends that each insurance carrier have the right to select its own time basis for measuring overinsurance, subject only to the requirement that this time basis be at least either 30 consecutive days or a calendar month.

(5) BENEFITS PAYABLE WHEN OVERINSURANCE EXISTS

The Study Group recommends that each insurance carrier should make such of its plans as contain an anti-duplication provision excess with respect to other valid coverage which does not contain such a provision. However, with respect to plans which do likewise contain an anti-duplication provision, each insurance carrier should have the right to use either a primary—secondary carrier approach or a proration approach to determine the benefits payable. Furthermore, regardless of the approach used, the insurance carrier may, if it so desires, allow the benefits of the other plan or plans to offset any deductible or coinsurance features required by its own plan.

It should be clearly understood that no carrier will pay out, in its chosen period of time, more in benefits under its anti-duplication provision than it would have paid in the absence of an anti-duplication provision.

(6) POLICY PROVISIONS

In the interests of the public, and more particularly in the interests of facilitating the handling of claims involving overinsurance, the Study Group recommends that the anti-duplication provision specify in complete detail such items as other valid coverage, the expense and time bases for measuring overinsurance, and the benefits payable when overinsurance exists, both when there is and is not another anti-duplication provision involved.

The Study Group also recommends that a facility of payment clause to other carriers be included whenever an anti-duplication provision is used in order to permit the handling of situations where one carrier has paid more than the amount of benefits it would pay in accordance with its anti-duplication provision and the other carrier has not. Such a clause should permit carriers to honor more quickly "authorizations to pay benefits to a provider of service."

(7) UNIFORM NOTICE OF OTHER COVERAGE

Finally, the Study Group Recommends that consideration be given to the development of a list of the pertinent data which one carrier should send another when it believes that multiple coverage may exist.

JAMES CHAPMAN,
New York Life Insurance Co.
 LINDSEY D. HANNA,
Connecticut General Life Insurance Co.
 HARVEY S. McGRANAHAN,
John Hancock Mutual Life Insurance Co.
 C. GILBERT NOREN,
Prudential Insurance Co. of America.
 LUKE O. TRAVIS,
Metropolitan Life Insurance Co.
 DANIEL W. PETTENGILL,
Chairman Aetna Life Insurance Co.

I INTRODUCTION

In the United States, an individual is free to choose both the extent to which he will insure himself against the costs of medical care and the means of doing so. In a growing number of instances, the individual obtains this protection from more than one source. To the extent that each source covers a different class of medical care expenses, such multiple coverage would appear to be harmless and perhaps even desirable. However, when protection against a given expense is obtained from two or more sources and the total of the benefits payable from all sources exceeds the amount of the expense, a situation, commonly known as overinsurance, is created.

One part of the overinsurance question is the incentive created for the insured to incur a particular medical expense for the purpose of reaping a possible substantial "profit" rather than incurring the expense solely out of medical necessity. This creates an unfavorable situation from the viewpoint of the suppliers of medical care, who look with disfavor upon any mechanism that permits the patient or the receiver of their services to make a profit from services they perform. A second part of the overinsurance question relates to the results that may follow when the provider of the medical service or supply concerned is tempted to raise his charge to the level of benefits available so that he, rather than the claimant, will profit from the duplication of insurance benefits. To the extent that such unnecessary medical care is used or such excessive charges are made, the total cost of medical care is increased and hence the cost of providing the insurance benefits for medical care is artificially inflated. It seems obvious, therefore, that insurance carriers, providers of medical services and the buying public all have an interest in minimizing the possibility of profit through overinsurance.

Medical care costs have been rising rapidly for over a decade and still show no signs of leveling off. Consequently, the public has become very cost conscious and will not be tolerant of unnecessary premium rate increases.

The precise extent of multiple coverage is not known, nor is the portion thereof which represents overinsurance known. The Health Insurance Council estimates that 12.9% of insured people have multiple coverage and a small sample study in 1959 by the Council revealed that approximately one out of every ten insured hospital patients had multiple hospital expense coverage which paid aggregate benefits of \$1.44 for every \$1.00 of hospital expense incurred.

Since over 128,000,000 Americans have some form of voluntary health insurance, and since the scope of the benefits provided by this insurance is constantly broadening, even a small percentage of overinsured persons can represent a substantial dollar hazard.

Another indication that overinsurance is a problem can be found in discussions with hospital administrators who have found accounting and collection problems as well as overutilization of hospital services. Where Blue Shield plans have a full service feature for low income groups, the participating physicians have become sufficiently concerned about overinsurance that they will seldom honor the full service feature when the individual has multiple coverage. Then, too, some medical review committees have declined to review claims involving questionable fees when multiple coverage existed.

One of the main sources of multiple coverage today stems from concurrent employment of both husband and wife. This is further augmented by the demands of a segment of organized labor for employer-pay-all insurance plans. In some such instances, both management and labor realize the economic waste of this multiple coverage and act to avoid it initially. More often, however, it is a premium rate increase that focuses attention on the problem.

With so many segments of the public concerned about overinsurance, it is obvious that insurance commissioners are also concerned about it. While relatively few states have specific laws on the subject, several state insurance departments are currently reviewing their position with respect to policy provisions dealing with overinsurance. Furthermore, two committees of the National Association of Insurance Commissioners are now jointly studying this very complex subject of overinsurance.

Group insurance carriers have made progress in handling the overinsurance problem, but much remains to be done. This is evidenced by the April, 1959 Survey of Use of Policy Provisions to Avoid Overinsurance conducted by the Health Insurance Association of America and sent to its member companies on December 28, 1959. It is essential that state laws and regulations, to the extent that they may be necessary, should permit a high degree of experimentation with policy provisions designed to control overinsurance in order that better solutions than now exist may be discovered, tested and implemented.

II GROUP UNDERWRITING CONTROLS AND THEIR LIMITATIONS

As far as any one group health insurance plan is concerned, it is both simple and practical to avoid overinsurance by limiting the benefits provided by the policy to not more than the actual charges incurred. This principle is generally followed today. Controlling the overinsurance that occurs through multiple coverage of a given type of expense is an entirely different matter however. If an employee works for two employers, both of whom have group insurance plans, the group carriers themselves are powerless to prevent multiple coverage. Indeed if both plans are union negotiated, even the individual employee is usually unable to avoid joining both plans.

A more common type of multiple coverage arises from the present day practice of covering not only employees but also their spouses and dependent children. A group policy may so define a dependent that only persons who are wholly dependent on the employee for support will be covered. If this approach is used, the group policyholder has the difficult problem of determining what constitutes dependency and then applying the rules to each employee. Very few employers are willing to undertake this difficult and distasteful task even though it would reduce multiple coverage. This approach is also unsatisfactory to labor because there are many nondependent spouses who nevertheless need the group coverage because no similar coverage is available at their place of work, or if coverage is available, it is not as broad as that provided by the employer of the employee.

A few employers are endeavoring to use a definition of dependent which makes ineligible any person covered under any other plan. If labor turnover is high, the administration of such a dependency definition is difficult. The employee frequently forgets to report changes in a dependent's status with the result that the employee has either contributed for a dependent's coverage long beyond the time the dependent ceased to be eligible or the employee has failed to request coverage for a dependent who no longer is covered elsewhere, with the result that a claim arises with no protection available at all. Moreover, this approach creates an undesirable situation when the dependent is covered as an employee under an inadequate non-contributory medical care plan under which she may not elect to discontinue coverage so as to become eligible under her husband's plan.

The foregoing applies primarily to duplicate group coverage. The very nature of group insurance, which is the mass enrollment of many persons without evidence of insurability, makes it impractical to avoid duplication of group insurance and individual insurance. When an employee is uninsurable or does not expect to stay covered under the group plan for very long, he may well desire to have individual coverage in addition to the group insurance coverage.

While sound group underwriting is essential, it is evident from the foregoing that underwriting can afford only partial control of overinsurance. It is equally evident that what is needed is a provision which will permit the regular benefits of the group plan to be payable when the individual has no other coverage, but

which will reduce these benefits to such a point that the individual does not make a profit when he has other insurance covering the same loss. Such a provision will be referred to hereafter as an anti-duplication provision. This provision seems like such a simple solution to the problem of controlling overinsurance that the casual observer is surprised to find that the relatively few group policies contain such a provision. The reason for the absence of such a provision lies partly in the history of group insurance and partly in the practical problems involved in administering an anti-duplication provision.

III. HISTORY OF ANTI-DUPPLICATION PROVISIONS AND PRACTICAL PROBLEMS INVOLVED IN THEIR USE

Fifteen years ago, group medical care benefits were modest—usually limited to hospital and surgical expenses. The amount of multiple coverage was small then and the risk of overinsurance was not considered significant by group underwriters. It was generally reasoned that any "profit" a claimant might make on his hospital expenses would be needed to pay his uninsured expenses, such as nurses, drugs, and other doctors' bills. Then Major Medical coverage was developed. This covered such a wide range of medical expenses that overinsurance could no longer be ignored. Hence, the insurance companies began to experiment with anti-duplication provisions in group Major Medical policies. This experimentation has indicated the following practical problems.

The initial reaction of both employers and employees to the use of an anti-duplication provision is that of opposition because people dislike having benefits reduced. Thus, substantial effort must be put forth by the insurance carriers to educate the public on the essential need for such a provision. Until the educational process has been accomplished, it may well be necessary to use anti-duplication provisions which are less extensive in scope than would be desirable for a tight control on overinsurance.

The tremendous importance of public support becomes apparent in the actual administration of an anti-duplication provision. In order to apply the provision, it is first necessary to determine the existence of other coverage. For all forms of individual coverage, and some forms of group coverage, the claimant is the primary, if not the only, source of information. Since no one likes to have his benefits reduced, there is a strong temptation for the claimant not to report other coverage. Indeed, many people feel it is essential to apply the anti-duplication provision solely to plans whose existence can be determined from some source other than the claimant.

It is necessary to determine not only the existence of other coverage but also the precise benefits payable by such other coverage. Since claim data is confidential, the permission of the claimant, the patient, and any group policyholders concerned, may be necessary before the insurance carriers involved can exchange the information necessary to permit settlement of the claim.

Even where full cooperation exists, the existence of an anti-duplication provision lengthens the amount of time required to settle a claim, particularly when other coverage does exist. This delay is intensified at the present time because most existing anti-duplication provisions do not precisely define when overinsurance shall be deemed to exist, and do not specify how claims will be settled when two or more of the plans involved have anti-duplication provisions. Insurance carriers can do much to minimize the extra settlement time required for the administration of an anti-duplication provision by the use of more precise policy wording. The carriers also need to solve such legal and accounting problems as may exist in order to facilitate prompt cooperation in the settlement of multiple coverage claims. For example, most hospital expense benefits today are paid directly to the hospital, pursuant to an authorization signed by the claimant. The insurance carrier receiving such an authorization to pay may feel obligated to honor it even though this means paying full benefits instead of the reduced benefits called for by the anti-duplication provision. In such instances, the carrier generally must attempt to make recovery of its overpayment from the claimant. When the carrier of the other plan has not yet paid its benefits, it would obviously be easier to recover this overpayment from the other carrier, rather than the claimant, provided a suitable mechanism for making such recoveries existed.

In spite of these problems, the demand for anti-duplication provisions continues to grow. Employers who have seen the effectiveness of such a provision in a superimposed Major Medical Benefit now want the provision to apply to the

underlying Basic Benefits as well. Furthermore, the rapid growth of Major Medical and Comprehensive Medical plans is making it imperative for employers with just Basic Benefits plans to request an anti-duplication provision in order to control overinsurance. Consequently, the insurance carriers need to intensify their experimentation with such provisions in order to make the language more precise and the application more practical.

In developing an anti-duplication provision for any type of group medical care coverage, the principal decisions to be made are as follows:

(1) What sources of overinsurance will be taken into account?

(2) When will overinsurance be deemed to exist in terms of amount of expense, type of expense, and time?

(3) How will benefits be reduced when overinsurance exists, both when the other coverage has no anti-duplication provision and when it does?

The balance of this paper outlines the possible decisions which might be made with respect to each of these three points. It should be understood that for any given claim it is administratively practical for different carriers to use provisions which vary in one or more respects.

IV. OTHER VALID COVERAGE

Any anti-duplication provision must define "other valid coverage", that is, which of the numerous potential sources of overinsurance will be taken into account in determining when overinsurance is deemed to exist and hence when the regular benefits payable under the policy should be reduced. Every potential source should be included in the definition of other valid coverage if the claimant is truly to be prevented from making a profit by reason of receiving medical care. There are practical considerations, however, which suggest that a more limited definition of other valid coverage is desirable.

Third party liability payments are a source of overinsurance which is almost universally ignored by the anti-duplication clauses currently in use. There are three important reasons for this. First, health insurance has traditionally based its benefits on the existence of a specified disease or injury, the insurance of a specified expense, or a combination of these two. The existence of a possible third party liability has not been a factor.

The above described nature of health insurance has generally permitted quick determination of the validity of any given claim, and hence prompt payment of policy benefits. This promptness has done much to win wide public acceptance of voluntary health insurance. The existence of a third party liability is not always readily apparent at the time of a health insurance claim, so that a lengthy investigation may be necessary to determine its existence. Even after the existence has been established, the determination of the amount of the third party liability usually takes months or even years. Thus, severe delays in claim settlement is a second reason for ignoring third party liability payments as a source of overinsurance.

Finally, there is the very practical problem that third party liability payments are usually of a lump sum nature, with no indication as to the portion, if any, attributable to medical care expenses. The claimant usually maintains that the settlement just covers his "pain and suffering" and that none of it covers his medical care expenses.

In those few instances where the group policyholder has required that third party liability payments be taken into account, the insurance carrier has usually omitted these from the definition of other valid coverage and relied instead on a "subrogation type" clause. When the employee is still employed with the group policyholder at the time the liability payment is made, the subrogation approach may work reasonably well. However, when the employer-employee relationship is gone, recoveries are difficult, if not impossible, to make.

Medical expense benefits under automobile and home-owners liability policies are payable without regard to who was liable. These benefits are essentially a form of health insurance and do not present the problems discussed above under third party liability payments. They do nevertheless present a problem in identification. While the existence of such insurance might be presumed in view of the wide-spread nature of automobile and home-owners insurance, actual identification of the insurance carrier and the amount of benefits payable depends almost entirely on the claimant's willingness to divulge this information. The dishonest claimant generally profits at the expense of the honest claimant. This can cause sufficient illwill among employees to spoil much of the goodwill the

employer tried to gain by adopting the group health insurance plan. Thus few, if any, of the standard group anti-duplication provisions in use today include as other valid coverage the medical expense benefits under automobile and home-owners liability policies.

Individual health insurance policies, that is, those covering just one person and his family, offer even greater problems of identification than medical expense benefits under automobile and home-owners policies. The benefits are usually payable for all types of accidents and, under many policies, for diseases as well.

Individual policies are commonly thought of as being purchased to supplement a group plan or to provide interim coverage. Thus when the individual pays the entire premium himself, most employees and some employers are unwilling to have their group benefits reduced by reason of the existence of such coverage.

Principally for these two reasons, group anti-duplication provisions generally do not count individual policies as other valid coverage. There are a few exceptions to this general rule. The most significant exception occurs when the individual policies are part of a *franchise plan* for which the employer makes payroll deductions. In this circumstance, the franchise plan is usually considered as a group plan and, since it is readily identifiable, it is included in the definition of other valid coverage. When there is no organized plan but the employer, as a favor, pays individual insurance premiums by payroll deduction for those few of his employees who request him to do so, many insurance companies administratively ignore such coverage even though technically it may be included in the definition.

Another exception, with which some companies are currently experimenting, is *individual (direct pay) Blue Cross-Blue Shield plans* and *Group Practice and Individual Practice Prepayment Plans*. Experiments are being made because these particular types of individual coverage usually have certain characteristics that may permit the identification of their existence without the claimant's help. Such plans are run by the providers of medical care who dislike profiteering by their patients and, therefore, may be inclined to reveal the fact that the claimant also has coverage under their plan. This should be particularly true when the Blue Cross or Blue Shield benefit is on a service basis, so that there is no direct charge for the care rendered. On the other hand, the patient can usually obtain a "bill" for presentation to the insurance company. Group Practice and Individual Practice Prepayment Plans can be detected when the claimant utilizes the services of a doctor who belongs to such a plan, provided the insurance company keeps itself informed as to the participating doctors. However, benefits for expenses paid for by the plan but not provided by the participating doctors are not easily detectable.

Group anti-duplication provisions generally include *other group plans* in the definition of other valid coverage. There are two main types, however. Some definitions include only plans for which the employer of the employee makes contributions or payroll deductions. Others include all plans for which any employer of either the employee or a member of his immediate family makes contributions or payroll deductions. This second type has several variations. Sometimes a family member is counted only if he is insured as a dependent of the employee. Sometimes the only family member counted is a husband insured as a dependent of a female employee. It should also be noted that the wording "employer—makes contributions or payroll deductions" does not encompass certain union and employee benefit plans.

Governmental plans are rare at the moment. Nevertheless, they are usually included in the definition of other valid coverage. Here again, there are two main types: plans actually provided by a government, such as Medicare, the plan for dependents of servicemen; and plans required by law, such as the hospital benefit under the California Unemployment Compensation Disability code. Much free care is given in governmental hospitals. To avoid overinsurance here, it is generally considered preferable not to rely on an anti-duplication provision but rather to include a special provision in the group policy which will exclude from covered medical expenses, expenses for services received which are or may be obtained without cost in accordance with laws or regulations of any government. "Any government" generally includes the Federal, State, Provincial or local government or any political subdivision thereof of the United States or Canada. If a charge is made to any person which he is legally required to pay, any benefits under the group policy are computed in accordance with the policy's provisions, taking into account only such charge.

It should be noted that some insurance carriers believe that other valid coverage for purposes of a group policy should include only governmental plans and plans written on a group basis. Other companies feel that complete freedom to experiment is essential. Both, however, realize the need to design and administer the definition of other valid coverage so that discrimination in favor of the dishonest employee is minimized. To do otherwise is to impair the public's goodwill.

V. EXPENSE BASIS FOR MEASURING OVERINSURANCE

Having decided on a definition of other valid coverage, the next step in developing an anti-duplication provision is to decide on the expenses with respect to which overinsurance will be measured.

Overinsurance will be said to be measured on an "each expense" basis when it is measured separately for each item of expense incurred with no consideration being given to whether or not other items of expense are overinsured or underinsured. Overinsurance will be said to be measured on a "total expense" basis when it is measured on the basis of all expenses combined. For example, if a claimant incurs a \$150 surgeon's fee and a \$30 assistant surgeon's fee for a given operation, and if he has two surgical policies, each of which would pay \$90 for the surgeon's fee and nothing for the assistant's fee, he is overinsured by \$30 on an "each expense" basis, but not overinsured at all on a "total expense" basis. It should be noted that these definitions are completely independent of the method or methods used to determine the benefits payable with respect to the various expenses incurred.

It is obvious that in between the two extremes of "each expense" and "total expense", there are a host of other methods for measuring overinsurance, depending on the degree to which various types of expenses are lumped together for purposes of applying the overinsurance test. When one of these methods is used, overinsurance will be said to be measured on a "compartmentalized" basis. When a plan provides several different benefits, it is quite common to make each benefit a compartment and to assign thereto all the items of expense used to determine that particular benefit.

A common example of compartmentalization is the lumping together of all necessary hospital miscellaneous fee charges into a single category. Thus, if there are two hospital expense benefit policies, each of which will allow \$100 toward hospital miscellaneous fee charges, overinsurance would be deemed to exist only if the total hospital miscellaneous fee charges were less than \$200. Hospital room and board benefits are sometimes a separate compartment while at other times, they are combined with miscellaneous fees into a single compartment. Consider, for example, the individual whose group policy provides a \$10 room and board benefit for 31 days and a \$100 miscellaneous fee benefit. Suppose that he has incurred room and board expenses for 10 days at the rate of \$25 a day and miscellaneous fee charges of \$150. If this individual has other valid coverage which has already paid \$100 toward the \$250 of room and board charge, and \$100 toward the \$150 miscellaneous fee charge, then this individual would be considered to be overinsured with respect to his hospital miscellaneous fees if these are compartmentalized separately from the room and board expenses. However, he would not be considered to be overinsured at all if all hospital expenses are considered as a single compartment.

The each expense basis is so contrary to the desires of the average claimant, and so impractical from the point of view of any coverage, such as hospital miscellaneous fee benefits, which combines several different items of expenses for purposes of determining the benefits payable, that no known antiduplication provision uses this measurement of overinsurance. The compartmentalized basis offers greater potential cost savings than the total expense basis. As is obvious from the last example given above, the narrower the compartments, the greater the potential savings. On the other hand, the total expense basis is preferred by the public for all types of benefits. It is also preferred by most insurance carriers for Major Medical Expense benefits. The total expense basis has the disadvantage that the claimant may be tempted to incur certain types of expenses with respect to which he is overinsured in order to secure the money to pay for other expenses with respect to which he is underinsured. In view of the current practice of authorizing the direct payment of benefits to hospitals, some carriers may look with favor on a compromise which uses the total expense basis except when all of the plans involved have a benefit structure which readily permits the compartmentalization of all hospital expenses. In that event, two compart-

ments would be used, one pertaining to hospital expenses and the second to all other expenses. It is not known how practical this compromise might be.

The total expense basis is not, a precise measurement per se but requires clarification as to what is meant by the word total. This suggests the need for setting up and defining two more terms. First, the term "covered medical expense" will be used to indicate an expense which a given plan would use to determine the benefits it would pay in the absence of other valid coverage. The term "allowable expense" will mean an expense which a plan would use to determine the benefits it would pay in the presence of other valid coverage.

At first glance, the latter definition seems unnecessary since most insurance carriers currently consider an allowable expense to be only an expense which is a covered medical expense under their own policy. In other words, their definition of an allowable expense is precisely the same as their own definition of a covered medical expense. The public, on the other hand, thinks of the term total expense as including every conceivable item required for the treatment of the disease or injury, including not only aspirin tablets and band aids but even swimming pools and air conditioners. It is obviously impossible to define total expenses in terms of the public's concept, but some broader definition than "covered medical expenses" is needed.

If allowable expenses are to be more liberal than the covered medical expenses of one's own plan, the insurance carrier has two possible approaches. First, it may define allowable expenses in terms of an arbitrary list of medical expenses. This approach has the advantage that the claimant always knows exactly what expenses will be taken into consideration when he has duplicate coverage involving that particular carrier. On the other hand, this approach has the disadvantage that some of the items of allowable expense may not be items which are covered medical expenses under any of the plans involved in a given claim. In this situation, the insurance carrier must go to the added trouble and expense of verifying the existence of all the noncovered medical expenses which it is going to recognize as allowable expenses. This approach also requires that a separate list apply to each combination of benefits offered by the carrier, or if just one list is used, that the list be at least as liberal as the most liberal combination of benefits offered by that carrier.

The second approach is to define an allowable expense, for purposes of duplicate coverage, in terms of the covered medical expenses of one or more of the plans involved. There are essentially three ways of doing this. The first is to define an allowable expense as "any necessary, reasonable, and customary expense, all or part of which is a covered medical expense under this policy." This way the carrier keeps types of insured expense limited to just those covered by its own plan, but waives any inside limits on amounts. For example, a plan that covers only the first \$20 of a private room charge would, under this definition, count a \$25 private room charge as an allowable expense.

The second way is to keep the inside limits on amounts, but to open the types of insured expense to all those covered by any one of the plans. For this purpose an allowable expense is defined as "any expense which is a covered medical expense under at least one of the plans involved." Here the most liberal private room limit of any of the plans involved would be enforced. However, if one of the duplicating plans paid for a hearing aid and the first plan did not, then under this definition the first plan would recognize the cost of the hearing aid as an allowable expense.

The third way simply combines the first two ways, and defines an allowable expense as "any necessary, reasonable, and customary expense, all or part of which is a covered medical expense under at least one of the plans involved."

What constitutes an allowable expense under the last two of these three variations can vary from claim to claim, depending on what other valid coverage is involved. Under all three ways the allowable expenses will be readily verifiable since the claimant will be under obligation to report them to at least one of the carriers involved. The third of these variations is the approach which now applies to the Government-Wide Indemnity Benefit Plan for federal employees.

Obviously, the insurance carrier needs to be protected against unreasonable charges; hence, the use of the phrase "any necessary, reasonable, and customary expense" in the first and third variations of the second approach. Thus, if all plans limited private room charges to the hospital's charge for semi-private accommodations, and if the average semi-private charge were \$20, a \$25 private room charge would clearly be a reasonable expense; whereas at least part of a \$50 per day private room charge would not be.

Whenever the total expense basis is used for measuring overinsurance and the definition of an allowable expense is more liberal than the plan's own definition of a covered medical expense, the anti-duplication provision must contain a special clause to the effect that in no event, will the benefits payable in accordance with this anti-duplication provision exceed the amount of benefits that would have been payable under the policy in the absence of this anti-duplication provision. This special clause protects the carrier in these situations where the total allowable expenses less the benefits actually paid by the other carriers equals an amount that is greater than the amount of the plan's own covered medical expenses.

VI. TIME BASIS FOR MEASURING OVERINSURANCE

A careful analysis of the foregoing section on the expense basis for measuring overinsurance will indicate that in every instance, a time factor has tacitly been assumed. An anti-duplication provision should specify the time basis which will be used in connection with the expense basis for measuring overinsurance.

The "each expense" basis for measuring overinsurance automatically assumes that time is measured instantaneously. All the other bases, however, assume some period of time over which either the compartment of expense is measured or the total expenses are measured. There is no perfect period of time for measuring overinsurance. From the point of view of the claimant, overinsurance should be measured against his entire lifetime, since only at his death, can it be truly said how the amount of benefits received compared with the amount of expenses incurred. This lifetime concept is just as impractical as the public's concept of "total expense." Therefore, each carrier will decide as to what period of time is to be used. The period of time used to measure the benefit payments themselves may furnish a suitable time basis for measuring overinsurance. For hospital benefits, this would be the period of hospital confinement, while for Major Medical benefits, it would be the benefit period.

Although different carriers can, and undoubtedly will, use different time bases, any one carrier may find it desirable to have a time basis for measuring overinsurance that does not vary with each coverage written. Thus, the carrier may pick some one period of time, such as the calendar year, to be used for all coverages. The longer the period of time, the less the potential cost savings will be since the individual's expenses are more likely to exceed his benefits. This is particularly true when the total expense basis is used. On the other hand, the whole purpose of using a total expense basis for measuring overinsurance would appear to be defeated if the period of time is less than 30 days or a calendar month.

It should be understood that the time basis can work both for and against the claimant. Initially, his benefits under a particular plan may be reduced because of an excess of benefits over expenses in the early part of the time period. If later in the period his expenses should exceed his benefits, he will then receive not only that plan's regular benefits for the subsequent expenses, but also a return of all or part of the amount of the previous reduction. On the other hand, once he has crossed the end of the time period, any amount by which the benefits of that particular plan are then still reduced will be written off and will never again be available to him to cover allowable expenses not otherwise paid.

VII. BENEFITS PAYABLE WHEN OVERINSURANCE EXISTS

The anti-duplication provision not only must define other valid coverage and the basis of measuring overinsurance in terms of both expenses and time but also must indicate how the regular benefits will be reduced when overinsurance is deemed to exist. There are two distinct parts to this problem. The first has to do with the benefits payable when all of the other valid coverage is on a "non-excess" basis, that is, it does not contain any anti-duplication provision. There are two general approaches used in this situation. The more common one is to determine the benefits of the plan on the basis of the net allowable expenses with full preservation of any deductible and coinsurance features that the plan may have. From the public's point of view, this approach has the drawback that the claimant cannot recover all of his allowable expenses except in the unique case where the other plans have entirely reimbursed them. The alternative approach is simply to pay a benefit equal to the difference between the individ-

ual's allowable expenses and the amounts payable by the other valid coverage, but, of course, no more than the plan's regular benefit.

The second part of the problem is to determine the benefits the plan will pay when one or more of the other plans are also "excess" plans, that is, they too have an anti-duplication provision. There are two common solutions to this second part of the problem in use today. One approach is for the excess plan carriers to assume a pre-determined sequence of responsibility for paying benefits. One carrier will take the role of primary carrier and will pay its regular benefit in full. (Note: If there should be one or more non-excess plans also involved in the claim, the primary carrier would reduce its regular benefit by the amount of the non-excess benefits payable). The other excess carrier will take the position of a secondary carrier and will determine its benefits on the basis of any unreimbursed allowable expenses remaining after the primary carrier has determined its benefits. The secondary carrier may invoke any deductible and coinsurance features of its plan or it may pay the entire balance of the unpaid allowable expenses. If there were other excess plan carriers involved, they would each take a successive position.

The second approach is for each excess carrier to pay a benefit equal to its pro-rata share of the individual's allowable expenses. (Note: If there should be one or more non-excess plans also involved in the claim, the total allowable expenses would be reduced by the amount of benefits payable by such non-excess plans and only the balance would be prorated among the excess plans.) The proration is usually determined in terms of the regular benefits which the carriers would pay in the absence of all other valid coverage. It is possible under this approach to prorate to any given percentage of the allowable expenses if it is desired to maintain an element of coinsurance.

In all of the above situations, it should be clearly realized that no carrier will pay out, in its chosen period of time, more in benefits under its anti-duplication provision than it would have paid in the absence of an anti-duplication provision.

Carriers which write Major Medical benefits to supplement a specified plan of basic benefits should also realize that they can no longer rely on the Major Medical anti-duplication provision to make the Major Medical benefit excess with respect to the basic benefits because of the possibility that the basic benefits may have its own anti-duplication provision, either initially or at some future date. Instead, the supplementary Major Medical plan should define its deductible as a cash amount plus the amount of benefits that would be paid under the basic benefits plan if the individual were covered thereunder and had no other valid coverage. Where the Major Medical carrier also underwrites the basic benefits, any anti-duplication provision for the basic benefits should exclude the Major Medical benefits from the definition of other valid coverage. This approach will make clear the fact that the basic benefits are not to be reduced when the only coverages in force are the basic benefits and the Major Medical benefit.

At the present time, there is no uniformity among the carriers as to the benefits payable when multiple coverage of a duplicate nature exists. Indeed, the anti-duplication provisions in use seldom specify the benefits that will be payable when the other valid coverage also has an anti-duplication provision. When the other valid coverage does not contain any anti-duplication provision, most carriers do invoke whatever deductible and coinsurance features may be in their plans in order to preserve at least some of the claim cost control which these features normally afford. The public would, of course, prefer that the coinsurance and deductible features be completely offset, to the extent that the other benefits are sufficient to do so.

With regard to the benefits payable when there is other valid coverage with an anti-duplication provision, a majority of the carriers use the first or so-called primary-secondary approach. This approach works well when the definition of other valid coverage is limited to Group and Governmental plans. Governmental benefits do not contain anti-duplication provisions and are therefore, always deducted first from the allowable expenses before determination of the insurance carrier's benefits.

The greatest degree of duplication among Group plans arises from the fact that the claimant will have coverage at his place of employment as an employee and at his spouse's place of employment as a dependent. In this situation, only two carriers are generally involved and it is thus possible to operate a predetermined rule whereby the carrier which insures the claimant as the employee is the primary carrier and the one which insures him as a dependent

is the secondary carrier. For dependent children, a different rule is necessary. Here it is customary for the primary carrier to be the one who has the children insured as dependents of the male employee. When the duplicate coverage arises by reason of the claimant's working for two different employers, still a different set of rules has to be established. No clear set of rules has yet been developed here but a possible basis for determining the primary carrier would be the one covering the major employment. If both employments were major, then length of time covered under the group policy could govern. Alternatively, proration could be used in this latter situation.

When just Group plans are involved, this primary-secondary carrier approach is relatively simple and quick to administer and to explain. When the definition of other valid coverage includes individual policies and the individual policy also has an anti-duplication provision, the selection of the primary carrier is not so simple. When just two carriers are involved, the group carrier might volunteer to be the primary carrier. It is not clear, however, what would happen if two or more individual plans were involved.

This primary—secondary carrier approach has the disadvantage that the carrier, and in turn the policyholder, may not receive an equitable share of whatever cost savings the anti-duplication provision may provide. It is obvious that the carrier of an all male group risk will be the primary carrier far more often than the carrier of an all female risk under which husbands are eligible as dependents. Another disadvantage occurs if the secondary carrier insists on preserving its deductible and coinsurance since, in that event, the total amount of benefits received by the claimant will vary fortuitously depending on which carrier is the primary carrier. This disadvantage is, of course, eliminated if the secondary carrier permits the benefits of the primary carrier to offset its deductible and coinsurance.

The second or so-called proration approach has the advantage that it works equally well regardless of what definition of other valid coverage is used and regardless of the number of different plans involved in any one claim. Furthermore, it does not require any arbitrary assumptions as to the sequence of responsibility. It, therefore, gives the experience-rated group an equitable share of any savings and yields the claimant the same total benefit. The proration approach has the disadvantage that it requires the determination of a mathematical ratio; a calculation which many claim clerks find difficult to comprehend and, therefore, may make mistakes with respect thereto. Furthermore, if a compartmentalized basis of measuring overinsurance is used, separate ratios must be calculated for each compartment of expenses. Thus, this method can be more difficult and slower to administer and to explain than the primary—secondary carrier method.

GROUP HEALTH INSURANCE ASPECTS OF OVERINSURANCE AGAINST HOSPITAL, SURGICAL AND MEDICAL EXPENSES—Two

Attached to this bulletin, for the information and guidance of member companies, is the Second Report of the Joint ALC-HIAA-LIAA Study Group on Non-duplication of Accident and Health Insurance Benefits. This report has been reviewed and endorsed by standing ALC-LIAA committees and HIAA committees.

This second report is a sequel to a previously distributed paper, authorized by the same study group, which was entitled "Group Health Insurance Viewpoints on Overinsurance" (See HIAA Group Insurance Bulletin No. 3-61, dated November 30, 1961). This original paper was essentially a background study of the problems posed by overinsurance in the group health insurance field when, through overlapping coverages, the claimant collects more in benefits than his total hospital, surgical and medical expenses insured against. The resultant profit making by the claimant causes difficulties not only in claim cost control but in relations between the providers of health care services and the insurance business.

After the original paper had been accepted, the study group was requested by its parent ALC-LIAA and HIAA committees to draft sample group policy provisions which would show how its recommendations could be implemented most effectively. Previous experimentation with anti-duplication provisions by different insurance companies had resulted in literally hundreds of different, and sometimes conflicting, provisions in use. Such multiplicity has caused some confusion and delay in claim settlement, and some dissatisfaction on the part of the providers of medical care and the insureds.

The study group concluded that the use of the sample group provision set forth in this second report would materially alleviate this situation, and at the same

time allow a high degree of flexibility. Its principles can also be adopted for use in connection with anti-duplication provisions in existing group policies where there is no direct contrary statement in the group policies as to the treatment of claims involving duplicate coverages.

As examination of the sample provision will show, it is a liberal one for the claimant. It is expected to be acceptable both to employee groups and to state insurance departments. It has not been presented formally to the National Association of Insurance Commissioners since, in contrast with the situation in the individual health insurance policy field, there are believed to be no statutory bars to its use. However, each state insurance commissioner is currently being sent a copy of the second report and of this covering bulletin.

The ALC, HIAA and LIAA believe that acceptance of the conclusions and recommendations of the study group will aid materially in resolving problems arising from overlapping and duplicating group health insurance coverages. This second report of the study group is, therefore, commended to your careful study and consideration.

This bulletin is also being sent to persons who receive HIAA Insurance Department Bulletins, the Committee on Economics of Financing Medical Care and its Overinsurance Subcommittee and Group Task Force and Individual Task Force, the Group Insurance Committee, Individual Insurance Committee, and Legislative Committee.

SECOND REPORT OF THE JOINT ALC-HIAA-LIAA-STUDY GROUP ON NON-DUPLICATION OF ACCIDENT AND HEALTH INSURANCE BENEFITS

Upon publication of its first report, the Study Group was requested to draft sample group anti-duplication provisions which would permit companies to implement the recommendations of the report. A sample proration provision was developed with relative ease but the development of a sample primary-secondary carrier provision was hampered by complex verbiage. After several drafts, this verbal log jam was broken by changing the name to "order of benefit determination."

In the course of this intensive work, it became apparent to the members of the Study Group that the Insurance Industry's primary objective of safeguarding health insurance for the public from the possible abuses of overinsurance through widespread use of anti-duplication provisions would be hindered rather than helped by the creation of many conflicting types of such provisions. Furthermore, in the field of Group Medical Expense insurance, the Study Group found some indication that employee dissatisfaction with the provisions already in existence might cause some of the employers who have been willing to experiment with such provisions to give them up. An analysis of this dissatisfaction revealed that the principal causes were:

1. Most existing provisions are silent as to the mechanics of their operation except on one point, namely, that the insurance company with the provision will pay last after all other carriers have paid their benefits. Hence, whenever both plans contain such an anti-duplication provision, the mathematical impossibility of two "last" plans is created.

2. In addition to the obvious delays in claim settlement caused by the above, there were other delays caused by wide variations in the administrative practices set-up by the carriers to implement the unwritten portions of their provisions.

3. Most of the existing provisions are in Comprehensive and Major Medical plans, and the carriers preserve the deductibles and coinsurance of these plans in applying the anti-duplication provision. This leaves the employee with out-of-pocket expenses. Since the employee does not understand the actuarial theory of group premium rates, he feels that because two premiums were paid, he should get two benefits, or at least he should get his medical expenses paid for.

After careful consideration of the foregoing facts, the Study Group came to the conclusion that it should prepare a single model group anti-duplication provision rather than a series of such provisions. As is so often the case, the decision was easier to arrive at than to execute. Nevertheless, by reason of a very generous amount of concessions on the part of each member, the attached suggested model provision has been drafted.

In the preparation of this draft, the group used two guiding principles. The first of these is the fact that an employer will accept an anti-duplication pro-

vision provided it permits his employees to recover their medical expenses. The second principle was that claim settlement should be simple.

It was on the basis of these two principles that the Study Group designed the model provision so as to reimburse the claimant up to 100% of his Allowable Expenses, with Allowable Expenses defined in the broadest practical manner, namely, "any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made." Simplification of claim settlement also accounts for the inclusion of the Sections entitled Right to Receive and Release Necessary Information, Facility of Payment, and Right of Recovery.

The most difficult problem which faced the Study Group was the choice between proration and order of benefit determination as the method for handling the determination of benefits among carriers each of which has an anti-duplication provision. As far as claimants are concerned, the aggregate amount of benefits produced by either method is essentially the same since the provision calls for reimbursement up to 100% of Allowable Expenses. From the point of view of Group policyholders, however, proration allocates any claim savings with a greater degree of equity. While this is an important point, it was felt that it was not an overruling one since the purpose of the anti-duplication provision is to prevent abuse from overinsurance rather than to produce claim savings.

As far as claim personnel are concerned, it was felt that with adequate training, either method could be used to settle claims reasonably promptly. On the other hand, substantially more claim personnel have been trained in the general principles of the order of benefit determination system than have been trained in the proration system since the latter system is currently employed by relatively few companies.

The Study Group finally decided to recommend an illustrative provision based upon the order of benefit determination system. The deciding factor was public understanding. The average person has difficulty in calculating a mathematical ratio and hence has difficulty in understanding how the amount of his reduced benefit has been figured when the proration system is used. The person can, however, generally understand the order of benefit determination system under which one carrier pays him his full benefit and the other generally pays him the difference between this benefit and his total Allowable Expenses.

The model provision contains four items which are variable. This may seem odd for a model provision. The explanation lies in the fact that the Study Group believes these four items can be variable without hurting the claimant and should be variable in order to meet the differing desires of Group policyholders.

The first of these items is Section A, "Benefits Subject To This Provision." This must be variable to permit necessary flexibility in the application of the provision.

The second of these items is the definition of a Plan. This item can clearly be variable without hurting the claimant since any Plan which is omitted from the definition automatically is ignored by this Plan in the determination of its benefits. If such other Plan wishes to take the benefits of this Plan into account, it is free to do so. While it is desirable to protect Group Plans against all possible forms of overinsurance, and some companies are planning to do so, it may not always be practical to do so. In some situations, the employer may need to be educated and in others, the carrier may need to gain experience. Hence, it may be preferable to start by simply taking other Group and Governmental coverage into effect. The definition of a Plan could then be expanded as necessary.

The third variable is the Claim Determination Period. Admittedly, this can have some effect on the claimant's benefits. At first glance, therefore, it would seem advisable to fix on a single Claim Determination Period. However, this is difficult to do since the public would like a lifetime Claim Determination Period; whereas claim personnel need as short a one as possible in order to have a manageable claim administration procedure. It would seem desirable to permit a certain amount of experimentation in order to develop more information as to what is an optimum Claim Determination Period. Tentatively, this would appear to be a calendar year. The calendar year is obviously well suited for Major Medical plans with calendar year deductibles. It is also well suited for Basic Benefit plans where each benefit has a different "successive disability" rule. On the other hand, it seems unwise to force a calendar year Claim Determina-

tion Period on those Major Medical plans which apply their deductible to a benefit period that is other than a calendar year.

The last variable item, item (5) of section (c), has to do with the actual allocation of the benefits paid to policy limits and by line of coverage. Obviously, if there are no internal policy limits and only one line of coverage involved, there is no allocation to be made. Since conditions may make a uniform allocation inadvisable—such as when Basic Benefits and Supplemental Major Medical are both subject to anti-duplication—this item should be variable.

It should be understood that the model provision will work with any of the anti-duplication provisions now in use. If the present provision is a proration one, then the carrier with the proration provision would pay its prorata benefit (after deducting, of course, the benefits payable by any plans with no anti-duplication provision), and the carrier with the model provision would pay the balance of the Allowable Expenses, but not more, of course, than its regular benefit. If the present provision is not specific as to the mechanics of its operation, but the carrier administers it on the so-called primary-secondary carrier basis, there will probably be few conflicts in order of benefit determination, and those that do result are to be resolved by the Plan with the model anti-duplication provision.

In addition to the model provision, which is attached as Appendix A, there is attached as Appendix B a set of notes on the provision and an Appendix C which contains numerical examples illustrating the application of the provision to actual claims. The insurance companies also need a better means of communication with each other when multiple coverage claims arise. To this end, the Study Group conducted a limited experiment in New York City during the summer of 1962, with a simple form designed to elicit not only the existence of other coverage but also the Allowable Expenses and the benefits payable. A modified version of the form used in the experiment is being prepared to reflect certain additional information required to operate the model provision. It is expected that this revised form will be available soon.

The Study Group believes that its suggested model provision offers insurance companies, employers, insurance commissioners, and the public a practical and hence desirable, solution to the vexing problem of overinsurance as it pertains to Group Medical Expense Benefits. The Study Group, therefore, urges its parent subcommittees to request their respective associations to determine the most effective method of disseminating the model provision to all interested parties and then to take the maximum action possible to see that dissemination is made by such method.

Respectfully submitted.

JAMES CHAPMAN,
LINDSAY D. HANNA,
HARVEY S. McGRATHIAN,
C. GILBERT NOREN,
LUKE O. TRAVIS,
D. W. PETTENGILL,
Chairman, Joint Study Group.

OCTOBER 22, 1962.

APPENDIX A

SUGGESTED MODEL GROUP ANTIDUPLICATION PROVISION

Provision for Co-Ordination Between This Policy And Other Benefits

SECTION A. BENEFITS SUBJECT TO THIS PROVISION

All of the benefits provided under this policy are subject to this provision.
(Note: When policy provides both integrated Major Medical Expense Benefits and the underlying Basic Benefits, but provision applies to Major Medical only, use the following alternate wording: Only the Major Medical Expense Benefits provided under this policy are subject to this provision.)

SECTION B. DEFINITIONS

(1) (Note: Include here the definition of a Plan, that is, the benefits, including those provided by this policy, that are to be co-ordinated. The following definition is illustrative only.)

"Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insurance coverage, (ii) individual and family-type insurance coverage, (iii) Blue Cross, Blue Shield, group practice, individual practice and other prepayment coverage, (iv) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (v) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(2) "This Plan" means that portion of this policy which provides the benefits that are subject to this provision.

(Note: Any benefits provided under this policy that are not subject to this provision constitute another Plan.)

(3) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(4) "Claim Determination Period" means-----

(Note: Insert here an appropriate period of time such as, "calendar year" or "Benefit Period as defined elsewhere in this policy.")

SECTION C. EFFECT ON BENEFITS

(1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of (a) the benefits that would be payable under this Plan in the absence of this provision, and (b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in item (3) of this Section C, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(3) If (a) another Plan which is involved in item (2) of this Section C and which contains a provision co-ordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and (b) the rules set forth in item (4) of this Section C would require this Plan to determine its benefits before such other Plan then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

(4) For the purposes of item (3) of this Section C, the rules establishing the order of benefit determination are:

(a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent;

(b) The benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers such person as a dependent of a female person;

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

(5) (Note: This item (5) may be omitted if the Plan provides only one benefit. The wording shown is illustrative.)

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be recharged against any applicable benefit limit of this Plan.

SECTION D. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Insurance Company may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Insurance Company deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Insurance Company such information as may be necessary to implement this provision.

SECTION E. FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Insurance Company shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be denied to be benefits paid under this Plan and, to the extent of such payments, the Insurance Company shall be fully discharged from liability under this Plan.

SECTION F. RIGHT OF RECOVERY

Whenever payments have been made by the Insurance Company with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Insurance Company shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Insurance Company shall determine: any persons to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

APPENDIX B

NOTES ON SUGGESTED MODEL GROUP ANTI-DUPPLICATION PROVISION

1. The terms provision, section, and item are not intended to be construed as model terms. They were simply the terms which were most convenient to use in drafting the suggested model provision. It is presumed that each company would vary these three terms to suit the format of its own policies.

2. The provision may be used for any Group Medical Expense Benefit or any combination of such benefits.

3. Some companies have written integrated Major Medical plans with only a cash deductible and have relied on the anti-duplication provision to provide the so-called "Basic Benefits" deductible. With the adoption of the suggested Model Group Anti-Duplication Provision, this approach will no longer be possible. Instead, the integrated Major Medical plan will have to use a two part deductible: one part a cash amount and the other part the policyholder's other benefits.

4. The provision has been designed to be included in the general limitations and exclusions section of the group policy and hence to apply to all benefits provided under the policy. If one or more of the benefits are to be exempt from the provision, then an appropriate change should be made in the wording of Section A. Sample alternate wording is included for the case where the Major Medical but not the Basic Benefits are subject to the provision.

5. The first paragraph of the definition of a Plan is intended to be completely variable. The illustrative definition shown is generally about as broad a definition as can be drafted consistent with sound public relations. (See Study Group's first report for reasons why liability payments should be ignored.) Some carriers may wish to limit the definition of a Plan to group and governmental plans.

6. The second paragraph of the definition of a Plan should always be included. This wording, which divides certain policies into two Plans, will be necessary as

long as there are group policies that apply the antiduplication provision to only part of their benefits.

7. The blank space at the end of the definition of Claim Determination Period will normally be filled by inserting "calendar year". This period of time is obviously appropriate for Comprehensive and Major Medical plans which apply their deductible on a calendar year basis. It is also well suited for Basic Benefits plans where the various benefits have different "successive disability" rules. "Benefit Period" would be used for those Comprehensive and Major Medical plans which apply their deductible on a Benefit Period basis and the Benefit Period is not a calendar year.

8. Attention is directed to the phrase toward the end of the third sentence of item 2 of Section C which reads "... and all the benefits payable for such Allowable Expenses under all other Plans ...". At first glance, it may seem that the phrase "in the absence therein of provisions of similar purpose" should be inserted after the word payable. This is not so, however, because it is intended that this Plan shall accept benefits actually paid as "benefits payable". For example, if the other Plan pays a pro rata benefit, it is intended that this Plan shall pay the balance of Allowable Expenses up to the amount of its benefits payable in the absence of this provision.

9. Although item 5 of Section C is variable, the wording shown has been designed to fit all types of plans. However, when there is an integrated Major Medical plan and both it and the underlying Basic Benefits plan are subject to anti-duplication provisions, then it may be desirable to vary this wording so that any reduction is applied first to the Major Medical Benefit.

10. Companies using this anti-duplication provision are expected to make every effort to instruct claimants to assign only the benefits of the Plan which is first in order of benefit determination. Even so, there will be situations where an HIC Hospital Admissions Form is executed with respect to the benefits of a Plan that is not first in order of benefit determination. In such a circumstance, the carrier of that Plan will honor the hospital assignment in full and will then look to the carrier of the primary Plan for reimbursement of any amount by which the payment to the hospital exceeds what would have been paid in accordance with the antiduplication provision. Note that Section E permits the primary Plan to make such reimbursement.

APPENDIX C

EXAMPLE ILLUSTRATING THE APPLICATION OF THE SUGGESTED MODEL GROUP ANTI-DUPPLICATION PROVISION

EXAMPLE I

Plan A provides: \$10 per day up to \$310 per hospital confinement for room and board, up to \$100 for hospital extras.

Plan B provides: The cost of a semi-private room for 31 days, up to \$200 for hospital extras, and up to \$200 for surgery.

Mr. Jones incurred the following expenses (all of which were "necessary, reasonable and customary") :

A private room for 5 days at \$20 per day-----	\$100
A semi-private room for 10 days at \$16 per day-----	160
Hospital extras-----	140
Surgeon's fee-----	50
"Physician's fee for in-hospital visits" (not related to surgery)-----	50
Total expenses-----	\$600

Allowable Expenses are \$550. The \$50 charge for physician's calls is not covered at all under either Plan A or Plan B, and hence is not an Allowable Expense. All other charges, however, are covered, either in whole or in part by one plan or the other, and hence are Allowable Expenses.

If neither plan had an anti-duplication provision, Plan A would pay a total benefit of \$250 and Plan B would pay \$530 (i.e., \$240 for room, \$140 for extras and \$150 for surgery). Mr. Jones would thus receive \$780 or \$230 more than his Allowable Expenses.

If Plan A has the Suggested Model Group Anti-Duplication Provision and Plan B has no such provision, then Plan A will determine its benefit payment by taking the total Allowable Expenses of \$550 and then subtracting the \$530 benefit payment of Plan B. The balance, or \$20, would be Plan A's payment.

If Plan B has the model provision and Plan A has none, then Plan B would pay the difference between the \$550 of Allowable Expenses and Plan A's benefit of \$250 or \$300.

If both plans have the model provision, then the plans will pay in their order of benefit determination. Thus, if Plan A covers Mr. Jones as an employee while Plan B covers him as a dependent spouse, Plan A would pay its full benefit of \$250 and Plan B would pay the balance of the Allowable Expenses, or \$300.

EXAMPLE II

Same as Example I except that the charge for hospital extras is \$140 instead of \$140. Total Expenses are \$900 and Allowable Expenses, \$850. Plan A normal benefit is \$250 and Plan B, \$590. Since the total of the two benefits normally payable is \$840 and this amount is less than the amount of Allowable Expenses (\$850), each plan would pay its normal benefit whether one or both of them contained the Suggested Model Group Anti-Duplication Provision.

EXAMPLE III

Plan B provides: The cost of a semi-private room for 31 days, up to \$200 for hospital extras, and up to \$200 for surgery.

Plan B provides: Comprehensive Medical Expense Benefits with a \$50 calendar year—all cause deductible, 80% rate of benefit and a \$5,000 maximum. Hospital private room charges are limited to the cost of a semi-private room.

Mr. Jones incurred the same \$600 of expenses as in Example I.

Now the Allowable Expenses are \$600 since all the charges are covered in whole or in part under one plan or the other.

Plan B has no anti-duplication provision and pays its \$530 of benefits.

Plan C would normally pay \$424. However, it has the Suggested Model Group Anti-Duplication Provision and, therefore, pays only \$70, the difference between the \$600 of Allowable Expenses and Plan B's benefit of \$530.

EXAMPLE IV

Assume the same Plans B and C as in Example III.

Mr. Jones has a second illness and incurs \$1,500 of physicians' fees, nurses' fees and prescription drugs, all of which is covered under Plan C (the comprehensive plan) but none under Plan B.

Assume that this second illness occurred in the same calendar year as the first illness and that Plan C has the calendar year as its "Claim Determination Period". This means that total Allowable Expenses are now \$2,100 and after deducting Plan B's payment of \$530, Plan C owes Mr. Jones a total payment for both illnesses of \$1,570. Since Plan C has already paid \$70 in connection with the first illness, it now pays the balance of \$1,500.

EXAMPLE V

This is the same as Example IV except that the \$1,500 second illness occurred in a subsequent calendar year.

Since the model provision applies separately to each Claim Determination Period, Mr. Jones cannot combine the expenses of the second illness with those of the first.

Since a different calendar year is involved and since Plan B pays nothing for the second illness, the model provision in Plan C is not applicable to the expenses of the second illness. Hence, Plan C pays its normal benefit of \$1,160, that is 80% of the difference between \$1,500 and the \$50 deductible.

Mr. Amos. I will take certain parts of it from time to time as I talk to you, and read them verbatim. And I will start off that way.

My name is John B. Amos. I am president of the American Family Life Insurance Company of Columbus, Ga. I am grateful for the opportunity to appear before you today.

I wish to acquaint you with some of the antisocial effects of "COB." the coordination of benefits clause found in most group accident and health policies and so highly praised before this committee by Mr. Johnson of the Aetna.

I also wish to defend my company against a knowingly false and reckless charge made by Mr. Denenberg, the Insurance Commissioner of Pennsylvania, before this committee, and in an explanation of his testimony when talking to the press later.

I have with me on my left Mr. Malcolm Hoffman, special counsel of the company, and Mr. Kenneth Henson, general counsel of the company, on the right.

Mr. Hoffman is handling two particular cases involving "COB" for my company in the Federal district courts. We are not here to try my lawsuit, but I do think that "COB" has certain antisocial effects that should be considered by this committee at this time.

My company, American Family Life, sells insurance against medical and hospital expenses resulting from cancer. We also sell a token amount of life insurance and other accident and health policies.

We sell our cancer plan policy in 42 States, the District of Columbia, the Commonwealth of Puerto Rico, and the United Kingdom.

During 14 years of writing cancer policies we have grown from a tiny company based in Georgia to the 10th largest writer of individual noncancelable accident and health insurance. We sell cancer insurance only to supplement other medical risk insurance policies, and we sell it because most of our subscribers wish peace of mind against the high probability that the insured or a member of his family will contract cancer.

We believe that these hearings would have been unnecessary had free competition prevailed in the insurance market. The free enterprise system has an innate way of fulfilling a need at a price the customer can afford to pay.

We do not compete with broad-based insurance; that is, the major medical or the group type broad-base. We come on top of that and add the extra moneys that are necessary to complete the payment of the hospital bills and the other incidental expenses that are incidence to a cancer case in the family.

What coordination of benefits does to us, it closes this market and constitutes a boycott.

Now, from the policyholder's standpoint, coordination of benefits are much, much broader than their application to us. Coordination of benefits works this way in the general case: It applies mainly when both husband and wife are employed.

The husband works for Ford Motor Co. and as a part of his salary, he gets family health insurance coverage. The wife works for General Motors and as a part of her salary or employment, she gets family health insurance coverage.

The idea was that they would reduce the risk, reduce the claims by setting down on overinsurance. Well, the insurance industry thus far has never demonstrated a correlation between overinsurance and utilization of hospital facilities.

This clause was adopted to take money out of sick people's pockets and put it either back into the hands of the employer, in some part to reduce rates, or into the treasury of the insurance company.

"COB" works, though, as I started to say, in the case of the man working for Ford and the wife working for General Motors, it sets up a priority of payments. And in that priority it says this: That if the husband gets hospitalized, his insurance carrier through the Ford

Motor Co. would pay first all of the allowable expenses provided for in the Ford Motor Co.'s policy.

Then if there was excess bills over the allowable expenses in the Ford policy, they would then call upon General Motors, the wife's carrier. They would go and take up whatever difference there was from the secondary carrier.

If a child is injured, hospitalized, the father's carrier is primary, the mother's carrier is secondary. And then the thing is switched around when the wife is injured and hospitalized. Her carrier is first and her husband's carrier becomes secondary, becomes secondary liability.

But it results in this: Mr. Hoffman and I are both working for Ford Motor Co. Mrs. Hoffmann doesn't work and Mrs. Amos does. A child is born in the family—in both families. We both get a \$500 hospital bill.

Mr. Hoffmann—in other words, Ford's carrier pays Mr. Hoffmann the full \$500. But me, because Mrs. Amos had worked and was covered, they take from what I would get out of my pocket and hand it back over there to Ford and their carrier.

Consequently, it boils down to taking money out of the sick person's pocket.

It's hard to boil this down in 45 minutes.

Senator HART. Mr. Amos, I should explain we have had a chance to read much of your statement. I have not read the whole, but the final pages.

Mr. Amos. Fine, Mr. Chairman. I can get right down to that.

First, Mr. Chairman, I would like to reply to Mr. Denenberg.

Mr. Denenberg came before this committee and told you that there was a cancer insurance company in Pennsylvania.

Senator HART. Is this the section you are prepared to testify about now?

Mr. Amos. Yes, sir.

Gentlemen, Mr. Denenberg, the commissioner of insurance for Pennsylvania, came before this committee and made charges involving my company which I consider to be both false and knowingly misleading.

At page 296 of the transcript of his testimony he spoke of cancer insurance and other dread disease policies saying: "They can be marketed at"—and this is a direct quote—"marketed at what seems to be a low premium because it is geared to return only a small percentage of premiums in benefits."

Later, at page 307 of the transcript, he says:

We have a company in Pennsylvania selling cancer insurance that is returning 7 cents on the premium dollar and, as I say, you can do better with the Pennsylvania lottery that returns 45 cents, which is better than auto insurance, and very close to being as good as individual health insurance.

Finally, in talking to the press he did not hesitate to identify the company referred to in this way as the American Family Life Assurance Co. of which I am president.

This committee will understand that we do not write cancer insurance for people who have cancer at the time when they apply for our policy. We write our insurance for anyone else. It is not to be expected that in the first few years of the policy's life the insured will contract cancer.

We have been doing business in Pennsylvania only since June 1970. I emphasize this circumstance because we had been selling policies in

that State for a very short period of 19 months at the close of business, December 31, 1971. Of course, we have only paid out 7 percent on claims in this short period.

Beginning our sales effort in Pennsylvania only in June of 1970, we issued only 1,712 policies during the entire year. It is logical to assume that most of these policies were issued in the last quarter and subject to a 120-day waiting period.

We issued 6,226 policies in 1971, and it is also logical to assume that most of these were issued in the last part of the year, because in the production of new business there is a spiral effect.

You have to sell the first policy before you can sell the next two. And you have to sell the first 10 before you can sell the next 20. The next 20 come in much easier than the first 10.

We, therefore, must conclude that because of the waiting period and this spiral effect our exposure in Pennsylvania during the year 1970 and 1971 was at a minimum.

The average age at the time of issuance of our policy is age 47, while the average at the time a claim is first submitted is age 60, 13 years.

We have monitored various blocks of cancer business over the years and they have aggregate loss ratios ranging from 30 percent to as high as 88 percent, the high ratio being associated with the older business.

We have experienced loss ratios by policy years as follows: The first year, 16 percent; second year, 30 percent; third year, 36 percent; fourth year, 42 percent; sixth year, 50 percent; eighth year, 60 percent; 10th year, 70 percent.

The latter group of projections based on experience to date of rather small blocks of cancer business issued in the beginning of the company's cancer insurance sales activities.

Mr. Denenberg, a self-proclaimed insurance expert whose total experience has been confined to the classroom and consultation, could not have failed to realize that there could be no meaningful payout experience in the Commonwealth of Pennsylvania until at least 6 or 8 years have elapsed.

We, however, must set aside a reserve for the payment of claims and we do this on a proper actuarial basis.

More significant than anything that Mr. Denenberg may say concerning our policy is the approval of our policyholders themselves who, for the most part, do not permit our policy to lapse, even though it is written on a yearly basis. They carry it through the time period when cancer is most likely to strike, and have every opportunity to learn whether or not it is worthwhile coverage.

The lapse rates of all our cancer business in force is as follows: Out of 100 policies, 20 lapse the first year, 15 the second, 12 the third, 10 the fourth, eight the fifth year, seven the sixth, and thereafter.

Mr. Denenberg may be disturbed that the court of Pennsylvania overturned his administrative ruling on our application, barring the sale of cancer insurance in Pennsylvania. But I see no need to go any further in defending ourselves against the charges of a man who stated to Senator Gurney's question, "The insurance companies will make a decision as to whether that appendectomy was done properly or not," transcript page 341.

So much for Mr. Denenberg.

The recommendations that I would have for this committee based on what I have said in written print, it is my belief that the free enterprise system carries within itself its own seeds of destruction. Left to its own devices and free of all restraints, it will destroy itself. It will freely fix prices, freely monopolize, freely boycott, freely destroy competition to the point that it is no longer free enterprise but controlled enterprise—controlled by the greedy and selfish few, turning out an inferior product at the highest cost the traffic will bear.

American industry was closely approaching that point around the turn of the century when Congress enacted the antitrust laws. Yet the largest industry in the country, dwarfing all other industries and combinations of giant industries, has been exempt from the protection of the antitrust laws, except in the limited case of boycott, coercion and intimidation.

I use the word "protection" because, in the absence of the antitrust laws, free enterprise would be a phrase foreign to the people of the United States in this year 1972.

I truly believe that we are faced with a health insurance crisis today because competition in the insurance industry does not exist. Yes, it exists at the local agent level, but at the top it is one big, happy family run solely for its own good by countless committees of over 200 insurance trade associations.

This industry, controlling assets in total approaching the size of the national debt of the United States, has the power to control the stock markets, to buy control of any industry, even to manipulate and fix the price of gold.

It cannot be allowed longer the absolute freedom that it enjoys outside the antitrust laws. It must not be allowed freedom to destroy itself as it apparently is doing in the health insurance field.

In closing, I recommend to this committee that it give serious consideration to the question of whether or not the insurance exemption embodied in the McCarran-Ferguson Act should be repealed by the Congress so that insurance companies are subject to the "Magna Charta" of free enterprise which is embodied in the Sherman and Clayton Acts.

"Magna Charta" was not my term. It's the term of Mr. Justice Thurgood Marshall in a recent decision.

Their constant exchange of competitive information, taking place in endless meetings, their joint activities expressed through hundreds of trade associations, their joint representations to commissions and governmental bodies as the end products of all agreements, all suggest that the insurance companies continually conspire together for their own benefit and to the disadvantage of the policyholders and the consumer at large.

I also suggest that this subcommittee call for the records of the insurance companies concerning the coordination of benefits, and we shall be glad to cooperate in such an investigation.

I believe that this committee will learn that overinsurance is related to the use of coordination of benefits is sheer pretext, and that the real purpose of "COB" is to reduce the payments to sick people who hold these policies.

Forced to compete, in the truest sense of the word, in the marketplace, the insurance industry of this Nation can and would rise to the occasion and provide fully for the health insurance needs of the population at a price the public would be willing and could afford to pay.

I thank you.

Senator HART. Cancer is the No. 2 killer in the United States?

Mr. AMOS. I think it is No. 1, Senator.

Senator HART. What is number one?

Mr. AMOS. I believe it is the heart.

Mr. CHUMBRIS. If it is not automobile accidents, it is pretty close.

Senator HART. Well, it is probably a question more out of curiosity than of relevance. Why did you pick cancer?

Mr. AMOS. Like every other product, I foresaw a market in it, and when I tested it, I found it to exist. I think the record of our sales, Senator, bears that out.

At the end of 1971, 50 percent of our business was less than 2 years old, and it had not lapsed off. It was because it just was spiraling. We did last year 25 million in premiums, we do about 37 this year, we should do close to 60 next year.

This is only because people want it. They want the peace of mind that goes with it. It is unbelievable how people are interested in cancer protection.

I have ladies in Columbus who know me, and call me, and say, "John, have a salesman"—one that I remember—"go by my son's cleaning establishment and try to sell him a cancer policy. Now, if you will go, he will listen to you and he will buy it. But if he doesn't buy it, I will buy it for him then."

It's that peace of mind.

Senator HART. Yes; I do understand. But the peace of mind you get is not that it will prevent the cancer, but that it will protect you and your family against the economic disaster that all of us have anticipated if cancer strikes.

Is that not right?

Mr. AMOS. We do not sell it as anything else but a financial medical supplement. But I do not buy airplane insurance because I am underinsured. I buy it because I feel like if I don't buy it this may be the very time the airplane is going to fall.

I am sure that plays some part in their persistence. They bought the policy, they have carried it, and they have a superstition about dropping it, I'm certain.

Also, of course, they would not buy it because of a superstition. They buy it because of the money that it would pay.

Senator HART. But as I understand it, the protection that it covers or the losses that it compensates for are enormously short of the economic loss experienced because of cancer.

Now, see if I am right. These are statistics from the Public Health Service. These, as we read them, show that for all ages the stays in the hospital for cancer comprise only less than 5 percent of all hospital stays for all ages, and only 7.2 percent of all hospital stays for all ages over 45.

Does that not mean that your chance of collecting under this policy for that cost is pretty remote because you do not begin to get compensated?

Mr. AMOS. Well, Senator, we are not selling any broadbased policy. We are selling a policy that pays in the event of cancer. It is special, and it is a product of our history. Special risk policies sort of follow the times, and the plague of the times.

Senator HART. Well, the average stay in the hospital for cancer is just about 15 days, according to this Public Health Service announcement. Under your policy that would mean that about all the policyholders would hope to collect from the average is less than \$600.

Mr. AMOS. Senator, that is where, with an average, you have got to have a top and you have got to have a low. Not a large part, but some of our claims arise from skin cancer that requires no hospitalization. But we also have people who stay in the hospital 60, 80, 90 or more days. The rates are fixed not on putting everybody in the hospital for 60 days, but as few in there for 60 days as possible. But to have the money there to pay for the man who does stay that number of days and what-not.

Senator HART. That is where Commissioner Denenberg would claim that the Pennsylvania lottery is a better investment than this policy, because the percentage who the 90 days is very, very small.

Mr. AMOS. Exactly. That is the reason we are able to do it. But the man who does hit 90 days, he is really out of luck, because practically everything else he has got has run out or been used up.

By the same token, out of \$500,000 automobile liability limits, they are available at prices we can afford to pay only because they do not get hit very often.

Senator HART. Have you bought one of your policies?

Mr. AMOS. Yes, sir. My daddy had one and collected on it. He bought the first one we ever issued.

Senator HART. How about counsel, do you have a policy?

Mr. HOFFMAN. Yes, I have a policy.

Senator HART. You had better see us, then.

Mr. AMOS. I had one agent who did not have a policy, and he has owed thousands. His wife died of cancer. He bought a policy, and he's now dying with cancer.

Senator HART. Mr. O'Leary.

Mr. O'LEARY. Mr. Amos, could you give me an idea as to the number or the percentage of your claims that involved a hospital stay of over 90 days? Do you have statistical data you could supply for the record?

Mr. AMOS. I would supply it for the record.

Let me say this: We started off as a very small company, and very few years ago. And we did not have our IBM systems in the very beginning, and it took time to perfect them and for the business to grow.

So we do not have statistics going from the very beginning of our experience, of 15 years ago or so. But we have statistics that go back within a reasonable period of time, that would give you some meaningful information.

Mr. O'LEARY. Along that line do you have a profile of any kind of the typical buver of your cancer policy, whether the individual is male or female and the age of the person who attempts to buy it, or income group and education?

Mr. AMOS. Only this: We do not have a profile that we set out to make up.

Mr. O'LEARY. Right.

Mr. AMOS. But we do know from our selling and our sales and our dealing with policyholders pretty much what we have got.

The quickest man to buy it is a banker because he knows that if he goes into the hospital that the government, the church, nobody is going to help him. He is going to have to write his own check for it. So he is buying bank account insurance.

We know that on the individual sales we have more women and older people in particular. And it carries with it a higher loss ratio. It is normal that it would have selection against us when we are getting the older people, and the cost also of hospitalizing a single person. And we sell a lot of individual policies in that age group, in the older age group.

But the cost of hospitalizing a single person is greater than hospitalizing a married person or a man with a family because a widow woman or a spinster, when she goes into the hospital, chances are she has almost got to be recovered before she can come out. There is no one at home to take care of them.

A lot of our business is employees of cities, counties, States. I would venture to say that not 50 percent, but a goodly percentage of the insurance commissioners in the States in which we do business and their offices are covered by group plans.

Mr. O'LEARY. What about income level? Do you have any idea? Do people with lower incomes tend to buy the policy more?

Mr. AMOS. Only on group. The lower income level does not buy it on an individual plan basis.

Mr. O'LEARY. Perhaps, for the record, we should keep our terms clear. You do not mean group, you mean franchise.

Mr. AMOS. When I refer to group, I do not mean a master group policy sold to an employer. I mean a group of policies sold to a group of people, a group of individual policies.

Our policy is the same policy contract, regardless of whether it is sold on a payroll deduction as a member of an association or door-to-door as an individual, isolated sale.

By the same token, concerning the question that you asked the last witness, if a man leaves a group, there is absolutely no change in his benefits nor his policy form. He keeps it. It is just that the rate goes up a little bit because we are now billing him individually and collecting it one at a time instead of a hundred at a time.

Mr. O'LEARY. Have you ever done any marketing surveys as to the kind of person who is most apt to be persuaded to buy your policy?

Mr. AMOS. No.

Mr. O'LEARY. As I understand—

Mr. AMOS. Let me say this: The underprivileged don't buy it. It is only bought in the middle-income and upper—or the lower-middle income and up. The only time we get a hard-working man, day laborer or someone like that, would be where it was withheld on a payroll deduction basis, or in a group, and we don't get many in that group.

Mr. O'LEARY. This policy is sold through an agent, right?

Mr. AMOS. It is.

Mr. O'LEARY. He comes around and persuades the individual that it is protection and——

Mr. AMOS. Right.

Mr. O'LEARY. Do you sell this at all by mail?

Mr. AMOS. Very little of it.

We are not a mail order house. The only mail solicitations we do is where we are soliciting a group. We may have the Georgia State Laundry Association—with a State association sponsorship, in order to get the franchise group moved in, and we will circulate their members by mail.

Mr. O'LEARY. And as I understand it, it has got to be diagnosed as a cancer in order to be covered. In other words, if I have a tumor and—or if I don't go to the hospital and I am operated on and it is found to be benign, I'm out of luck.

Mr. AMOS. If it is benign, you are out of luck but—(laughter)—you are out of luck, right. Do you want to correct that statement, sir.

Mr. O'LEARY. No, no.

It is fair to say that it is not a hospitalization policy in the ordinary sense.

Mr. AMOS. Now let me tell you the situation that it does pay in. It pays where the cancer is inoperable whether or not there is any tissue removed. We use a rule which we have found to be trouble free: If the diagnosis, the quantiful diagnosis is consistent with cancer, and inconsistent with any other reasonable diagnosis; and if the treatment is consistent with cancer, then we pay—we accept the claim even in the absence of pathology.

Because you can't ask them to kill a man to get you enough path to pay a claim. This has been a process of evolution. The policy we have today bears little resemblance to what it did 15 years ago, and probably will in another 5 years.

For instance, the preexisting condition we used to contest. A man would buy a policy and it had no waiting period, but if we got a claim in 10 days, and the tumor was as big as a watermelon, well you had some reason to believe that it might have existed prior to the time that he bought the policy. But it was a maker of ill will. It certainly caused some litigation. It caused settlements in cases. About 4 or 5 years ago we adopted a new rule. We put on a waiting period. Then we said that after that waiting period that we would not worry about preexisting conditions. That if the man had never had a cancer prior to the end of the 120th-day following the issuance of the policy, in his entire lifetime, diagnosed; then if it has been—or had been manifest or non-manifest in his body for 10 years, we still accept liability.

We go on date of diagnosis. Now I might add with reference to the process of evolution that we are closely approaching reducing the waiting period to 30 days, or eliminating it altogether because we have experience now to determine just what our liability would be under those circumstances.

We are trying to do a fair job for the cancer victim.

Mr. O'LEARY. You don't feel that someone is better off taking his money that he would put into your policy and buying better comprehensive care; a better policy that covered everything?

Mr. AMOS. Counsel, the only answer I can give you to that is that I figured out the other day, since I got out of law school—I bought 28.

automobiles. In 21 years. If you are going to measure everything in what is the best buy, what we should do, all right. But I think you still have to give the individual some responsibility for his own destiny.

Mr. SHARP. I guess it is fair to say, Mr. Amos, that you believe that the health destiny of the individual is under his own control; is that a fair statement based on your last statement?

Mr. AMOS. It is not under the present system. He has no control over what kind of insurance he is going to get.

Mr. SHARP. I'm not talking about insurance. I am talking about health care. I'm talking about the fact that we have pollution; we have many other environmental factors. Are you suggesting that "individual responsibility" is going to cure these problems?

Mr. AMOS. I am not. I am not. I think the Government has got to take the big lead. If there is any answer to the delivery of health care at reasonable cost, it doesn't lie within the power of the insurance companies to solve.

Mr. SHARP. It doesn't?

Mr. AMOS. It does not.

Mr. SHARP. You are suggesting then that someone else should be doing this, not just the individual, but the body politic which is representing the individuals?

Mr. AMOS. The body politic. I don't know that that is going to be any answer. As far—as fast as the whole thing is tied to our inflationary spiral, and there is no escaping, the Government itself is then in that inflationary spiral.

Mr. SHARP. Well, let me ask you, speaking of inflationary spiral here, getting to the question Mr. O'Leary just asked you—just carrying it one step further—if for example I had a very good comprehensive health care policy, giving me hospital care, surgical benefits, extended care facility benefits—by the way, your policy doesn't as I read it, cover extended care facility benefits, does it?

Mr. AMOS. It covers unlimited hospitalization.

Mr. SHARP. Just hospitalization?

Mr. AMOS. Right.

Mr. SHARP. In short, I have to be in a hospital to collect. If I am dying from cancer I have to stay in that hospital to collect.

Mr. AMOS. You are going to need to stay in that hospital.

Mr. SHARP. Pardon?

Mr. AMOS. You are going to need to stay in that hospital.

Mr. SHARP. I can't go home to my loved ones and die.

Mr. AMOS. People from extended care facilities where they have been there for sometime else, go to the hospital for cancer.

Mr. SHARP. Well, today many people in this Congress are pushing for a program, various programs, that would take people out of the hospitals and put them into extended care facilities, a progressive treatment kind of program. Get them into qualified day care and nursing homes or qualified home care. As I understand it, and as I read your policy, none of this is available to the unfortunate person with a malignant cancer.

Mr. AMOS. Exactly. And I can make it that way.

Mr. SHARP. Why don't you?

Mr. AMOS. Because the public won't pay the premium. It costs—for \$150 a year I can do everything you are talking about.

Mr. SHARP. Why won't the public pay the premium?

Mr. AMOS. It is just my opinion, I haven't tried to sell it.

Mr. SHARP. Why would you think that. Just assume you are a businessman. Why do you think that the public wouldn't buy it; I mean, just as to your cancer policies.

Mr. AMOS. That is just my opinion. I haven't tried it. But I don't believe they would pay \$150 a year for cancer insurance, where they will pay \$50 for a smaller package of cancer insurance.

Mr. SHARP. Now you made one statement that was of interest. You say that the Blue Cross doesn't pay for blood, and you are kind of leaving the impression that the Blue Cross people are putting their monetary consideration ahead of service at a time of greatest need.

Isn't it true, sir, that the hospitals tell the Blue Cross not to charge for blood because they are not interested in the money. They say they want to keep the blood banks replenished. So when you make the statement that you did in your statement, isn't that kind of implying that the Blue Cross doesn't pay for blood and your advertising says the Blue Cross doesn't pay for blood. Don't you feel that is misleading advertising?

Mr. AMOS. I am—in the first place I am not advertising what Blue Cross does or doesn't do. That is a statement that I wrote for this committee and this committee alone.

Mr. SHARP. Well, why? Why would you tell us something like that?

Mr. AMOS. Let me see it in context. I was showing that Blue Cross was not 100-percent coverage.

Mr. SHARP. Blue Cross won't give you the blood. Blood is supplied by the hospital as a service and they don't charge for it.

Mr. AMOS. Are you saying that Blue Cross does not have to pay for blood but it gives it to you? Does it go get the donor?

Mr. SHARP. If I am covered under Blue Cross, the hospital says they don't want Blue Cross to charge for the blood. The reason is that—not that they are callous and indifferent to the needs of the patient, but it is a fact that they wish to keep the blood banks replenished.

Mr. AMOS. Well I—I am surprised that that is the situation. I have yet to hear the possibility that we do not pay for blood or anything else.

Mr. SHARP. Well, now, moving on here, you have given to the subcommittee on the last page in your presentation some statistics. I'd like to run through some of these statistics here that were presented to the subcommittee.

Mr. AMOS. Yes, sir.

Mr. SHARP. Now, using the lapse rates, percent of policies found at the bottom of page 4, lapsing in policy years, and the loss ratios in the middle of that page, the subcommittee staff has computed the loss ratio for a block of business to be 42 percent.

In short, what we've done, basically, is to take the simple average and weight it for policy terminations. And when we do that, we come out with a 42-percent payout.

Isn't this an awfully low payout when, you say, much of your business is sold on a franchise or a quasi-group basis where the premiums for this franchise insurance are secured through payroll deduction?

Mr. AMOS. Now, I'm not an actuary and I'm not qualified to get

very deep into this field, but I would think that averaging would not be proper because the longer you hold a policy, the more likely we are to have to pay.

Mr. SHARP. Well, sir, let's go into that statement of yours. Let's examine it carefully because, Mr. Chairman, we will present for the record, the actuarial assumptions made for the table including the calculations of this weighted loss ratio, which, by the way, the last page of the Occidental Insurance Co. statement on the 20-year major medical policy indicates that it is the common practice to weight the loss ratio by the number of policies terminated for any given block of business. So, I ask that this table be included in the record.

(The document follows.)

AMERICAN FAMILY LIFE (CALCULATION OF WEIGHTED LOSS RATIOS)

[In percent]

Policy year	Lapse rate (1)	Remaining in- force at year end (2)	Loss ratio (3)
1	20	100	16
2	15	80	30
3	12	68	36
4	10	60	42
5	8	54	46
6	7	50	1 50
7	7	47	1 55
8	7	43	1 60
9	7	40	1 65
10	7	37	1 70

¹ Projected by company:

$$\frac{\sum_{1}^{10} \text{Col. (2)} \times \text{col. (3)}}{\sum_{1}^{10} \text{Col. (2)}} = 42 \text{ percent.}$$

Mr. AMOS. Counsel, let me get it straight now. You are conceding now that we would have 42 percent instead of 7 percent on that basis you're talking about.

Mr. SHARP. Yes; because I'm talking about a block of business.

Mr. AMOS. I've gained 37 percent, I believe. [Laughter.]

Mr. SHARP. Of course, we're taking out the State of Pennsylvania. We're taking the national figures that you've supplied to us. We're just taking that data, Mr. Amos.

Now, you state that the average age at the time of issuance of that policy was 47 years of age?

Mr. AMOS. Yes.

Mr. SHARP. You then say that on the average—

Mr. AMOS. Let me qualify that. That does not take in consideration children, because we only count the adults.

Mr. SHARP. And the average age at the time a claim is first submitted is the age of 60?

Mr. AMOS. Right.

Mr. SHARP. Then you go on to say at the bottom of page 4, in speaking about Commissioner Denenberg, you talk about the approval of

our policyholders themselves, for the most part, do not permit our policy to lapse even though it is written on a yearly basis.

They carry it through the time period when cancer is most likely to strike. I take it that that's your feeling of the people carrying your policies?

Mr. AMOS. Right.

Mr. SHARP. They might take one out at 47, and "I'm going to keep that policy——

Mr. AMOS. Right.

Mr. SHARP. Because I don't want to be caught." Right?

Mr. AMOS (Nodding head).

Now, using some very simple arithmetic here, looking at the bottom of page 4, we get the percent of policies lapsing in a policy year, for your block of business, is that true?

Mr. AMOS. That's what my staff came up with. I believe it, yes.

Mr. SHARP. It's true, isn't it?

Mr. AMOS. Yes.

Mr. SHARP. These figures are correct?

Mr. AMOS. To the best of my knowledge and belief they are. I didn't calculate them, they were calculated by my——

Mr. SHARP. Well, let's start with the percent of policies lapsing in policy year 0 because, on January 1 of policy year 0, we have none, but at the end of that year, we have 100 policies written.

So, the first year, 20 percent of those policies have terminated——lapsed?

Mr. AMOS. Right.

Mr. SHARP. That leaves us with 80?

Mr. AMOS. Right.

Mr. SHARP. Right. Then if you take 15 percent of the 80, you come up with 68 left.

Now, you say for the first 6 years it's 20%, 15%, 12%, 10%, 8%, 7%, and for every year after 6, it's 7%. We did a little calculating here, Mr. Amos, and over the 13-year period, starting with 100 policies, you'd wind up with 28 policies. Do you follow me, what I'm trying to say?

Mr. AMOS. Wait a minute now. I explained, counsel, as I read it——

Mr. SHARP. I'm sorry.

Mr. AMOS. This is not a percent of the declining balance. It is a percent of the original 100 policies.

Mr. SHARP. Of the original 100 policies?

Mr. AMOS. Exactly.

Mr. SHARP. 20 percent——

Mr. AMOS. We've got 80 left at the first year.

Mr. SHARP. How many do you have left at the end of the second year?

Mr. AMOS. 65.

Mr. SHARP. How do you figure that?

Mr. AMOS. That's just what our figures show.

Mr. SHARP. I show 68. I'm giving you the benefit of the doubt.

Mr. AMOS. Well, if we have 80 and we take 15 off of it——

Mr. SHARP. You get 15 percent of 80, which is what?

Mr. AMOS. No; we're not dealing in percentages. That's what I was saying. This is based on the 100 policies.

Mr. SHARP. It says here, sir "20 percent." I'm just giving you—

Mr. AMOS. And I corrected it when I read this statement for this committee. I said this relates to the full 100 policies. In other words, 20 percent of the full 100 the first year, 15 percent of the full 100 the second.

Mr. SHARP. All right. Wait a minute. Twenty percent of the first 100 gives you 80, right?

Mr. AMOS. Right.

Mr. SHARP. And 15 percent of the full 100 gives you 15, right?

Mr. AMOS. Right.

Mr. SHARP. Now, what are you doing? Are you subtracting the 15 from the 80 at that juncture?

Mr. AMOS. Right.

Mr. SHARP. Fine. That gives you 65, right sir?

Mr. AMOS. Right.

Mr. SHARP. Then what do we do for the 12—take 12 percent of the 100?

Mr. AMOS. Twelve percent of 100.

Mr. SHARP. That gives us 12, right?

Mr. AMOS. Uh-huh.

Mr. SHARP. That comes out 53. Then we take 10 percent of 100, gives us 10, and 43 left. Then we take 8 percent of 100, or 8, which gives us 35 left. Then we take 7 percent of 100, and we're down now to 28 left.

Now, were going into our seventh year. We take 7 percent of 100 and were down to 21, sir. So, we're going down to 0 and minus by the end of the 10th and 11th years.

Mr. AMOS. Some of this is wrong. Let me explain to you. All right.

Mr. SHARP. I'm not trying to joke with you. I'm not trying to embarrass you sir, really. You have presented figures here and we're just trying to understand.

Mr. AMOS. Now, what I'm trying to say is this.

Mr. SHARP. Yes, sir.

Mr. AMOS. That this, for instance this 20 percent could lapse in 1 month, or it might be the first exposure. I'm going to say I can't answer you. There's a discrepancy somewhere because it doesn't stack up with my premiums.

Mr. SHARP. Well, would you do us a favor? Perhaps you will supply for the record the—

Mr. AMOS. I would clarify it for the record at this point.

Mr. SHARP (continuing). Clarification and give us your actual assumptions as to any lapsation data. And which tables are used?

Mr. AMOS. I will give you the actuarial data, the actual data, and then you can take it on from there.

Mr. SHARP. Mr. Chairman, I would like to introduce for the record, the policy Form A4474 and advertisings which is their major selling cancer policy.

Mr. AMOS. Yes, sir.

Mr. SHARP. The monthly vital statistics report of the national center for health, statistics and additional data supplied, and as well as, Mr. Chairman, a letter received from a constituent not of yours, Sena-

tor, but a Virginia resident who wrote to you under date of June 1, 1972. And she's calling our attention to a Washington Post article, and I'd like to put this article into the record and the attached article from the Post.

Mr. HART. Fine.

(The documents follow. Testimony resumes on p. 1173.)

FAIRFAX, VA., June 1, 1972.

Senator PHILIP A. HART,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HART: Your attention is invited to the reproduced copy of an article which appeared in the Washington Post, Friday, May 12, 1972.

It may interest you to know that we, the employees of the Office Secretary of Defense, DOD, were offered this health insurance by the Welfare and Recreation Association of the Department of Defense, Room 3C 1057, Pentagon, and I was one of the subscribers. I did not pay my semiannual payment of \$12.00 (\$24.00 per yr.) because of this information.

I don't know what it is, but when the Federal government employees are sucked in on a thing like this, how can we believe anything else.

I just thought perhaps you should know that maybe we have been exploited.

Sincerely,

Mrs. FRANCINE DAVIS.

[From the Washington Post, May 12, 1972]

MASS-MARKETED INSURANCE HIT BY P.A. OFFICIAL

(By Morton Mintz)

Pennsylvania's maverick state insurance commissioner, accusing commercial insurers of mass-marketing individual health policies he called "junk" and "nothing short of fraud," urged Congress and state legislatures yesterday to consider laws to remove the companies from the market "immediately."

"The public would be better served" were the non-profit Blue Cross plans to acquire a monopoly, Commissioner Herbert S. Denenberg told the Senate Anti-trust Subcommittee.

"These plans return in benefits 97.3 cents of every premium dollar," Denenberg said. Even private group health plans return 96.1.

But, he testified, a survey of 916 of the more than 1,200 companies selling individual illness and accident policies showed that they returned only 53 cents on the premium dollar.

Pennsylvanians holding "a notorious cancer policy" got only 7 cents on the premium dollar from a firm that Denenberg identified to a reporter as American Family Life Assurance of Columbus, Ga. [Offered to Office of Secretary of Defense employees (OSD, Dept. of Defense) through Welfare and Recreation Association, Room 3C 1057, Pentagon.]

"The public is being taken," he said. Subcommittee Chairman Philip A. Hart (D-Mich.) agreed. The companies are profiting from "a sort of harvest of ignorance," he said.

The companies have sold an estimated 43 million individual policies, directly affecting that number of owners plus possibly 17 million family members. Another 13 million persons hold policies that replace income lost as a result of disability.

The subcommittee staff said that the Combined Insurance Group—five firms headed by W. Clement Stone of Chicago, President Nixon's principal recorded campaign contributor—paid 40 cents in benefits out of each dollar collected on policies providing for disability income.

The staff data—based entirely on the group's own figures for 1971—showed that 41 cents went for administrative expenses, 14 cents for profit and 5 cents for federal and state taxes.

A similar staff exhibit for the MacArthur Insurance Group—mainly Bankers Life & Casualty Co.—showed that of each premium dollar derived from individual hospital and surgery policies, 51 cents was paid out in benefits, 44 cents in administration expenses and profit and 5 cents in taxes.

Stone had been scheduled to testify but sent a letter to Hart saying he was in London to fulfill a speaking engagement.

Testifying in his stead, Edmund G. Pabst of Chicago, executive vice president of the Combined Insurance Co. of America, said that commercial carriers "are returning a sufficient amount in benefits" to individual policyholders.

"Clearly the American public wants and needs both individual and group protection," Pabst asserted.

His firm, which accounted for one-tenth of the group's 5.5 million policyholders, received \$240 million in premiums last year on life and accident and health policies.

Commissioner Denenberg charged the health insurance industry with having done "little more than shovel money back and forth between policyholders and providers" of health care. But he acknowledged under questioning that the system is so structured as to provide little or no incentive to Blue Cross and Blue Shield plans, either, to try to hold health-care costs down rather than simply to pass them through to consumers.

Moreover, Hart said, it's "in the cards" of the existing profit-motivated system that no one with a really serious health problem can count on getting "adequate health insurance."

Denenberg, in an exchange with Sen. Edward M. Kennedy (D-Mass.), said that intense "micks" rather than better insurers produces "new gimmicks" rather than better services and lower prices.

Most mass-marketed policies include little or no out-patient coverage but emphasize much more expensive in-hospital coverage.

HOSPITAL DISCHARGES,¹ UNITED STATES, 1968—LENGTH OF STAY IN HOSPITAL

[In thousands]

	Malignant neoplasms			Benign neoplasms and others		
	All ages	Under 65	65 and over	All ages	Under 65	65 and over
30 days or less.....	921	529	393	876	802	75
31 days or more.....	123	59	63	7	5	2
30 days or less (percent).....	88.2	91.5	86.2	99.2	99.4	97.4
				All ages	45 and over	
Total discharges—excluding obstetrical.....				23,887,000	12,028,000	
Malignant neoplasms.....				1,044,000	866,000	
Percentage.....				4.4	7.2	
Average length of stay, excluding obstetrical (days).....					9.2	
Average length of stay, malignant neoplasms (days).....					15.3	

¹ Includes discharges due to death.

Source: National Center for Health Statistics, U.S. Public Health Service, HEW.

MONTHLY VITAL STATISTICS REPORT—HOSPITAL DISCHARGE SURVEY; PROVISIONAL DATA: FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

UTILIZATION OF SHORT-STAY HOSPITALS, 1968

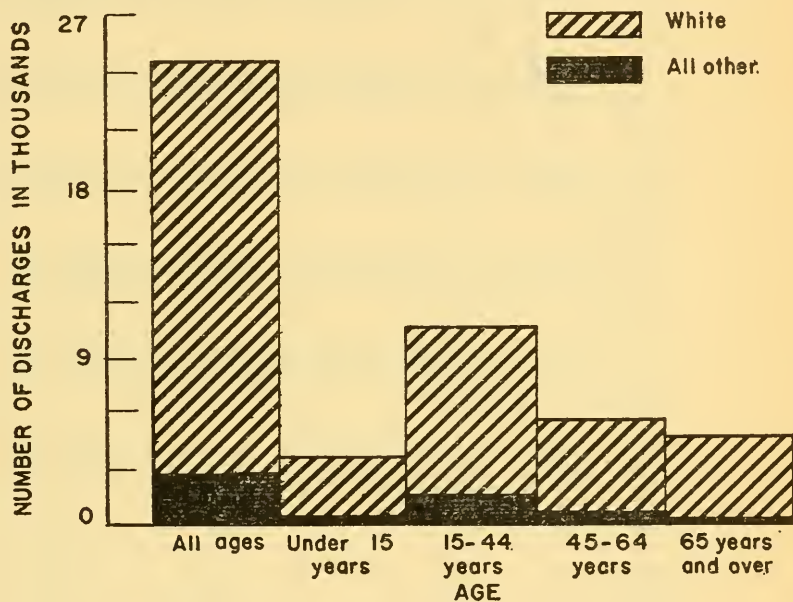
This report presents summary estimates on patients, excluding the newborn, who were discharged in 1968 from short-stay hospitals in the United States. Information is included on their number, rate per 1,000 civilian, noninstitutional population, days of care, and average length of stay by various patient characteristics and region of the country in which they were hospitalized. (For definitions of terms used in this report, see Technical Notes.)

Number of discharges.—During 1968 over 28 million patients were discharged from short-stay hospitals. Of this number, data by color and discharge status were available on 24.4 million, of which 21.6 million were white patients and 2.9 million were patients other than white (fig. 1).¹ Each group discharged 97 percent of the patients alive.

Two of the four geographic regions, the North Central and the South—with more than 8.6 million patients each—had the largest number of discharges. The West—which had slightly less than half the number of patients as the other two regions—had the smallest number of discharges, 4.2 million (table 1).

Almost half of the 28.1 million discharges were patients between 15 and 44 years of age (table 1). Females, including those hospitalized for deliveries, accounted for over half of the total hospitalizations. But even when deliveries were excluded, females represented approximately half of the total discharges (table 1).

Figure 1. TOTAL DISCHARGES BY COLOR: UNITED STATES, 1968



¹ Statistics on color must be used with caution since the number for whom color is not stated (3,497,000) is larger than that for the all-other color category (2,895,000).

	Days of care in thousands				Average length of stay in days					
	1,726	363	575	548	240	59.1	54.5	70.0	58.6	48.3
Under 15 years	5,327	1,145	1,580	1,786	816	131.1	118.0	142.7	137.0	119.4
15 to 44 years	3,383	767	1,024	1,054	537	160.8	134.7	174.4	170.8	163.0
45 to 64 years	3,015	677	965	949	425	288.7	243.7	321.8	305.7	271.2
65 years and over										
Both sexes: ¹										
All ages ²	237,201	62,308	76,076	68,871	29,946	8.5	9.9	8.8	7.8	7.1
Under 15 years	19,999	4,841	6,876	6,142	2,140	5.0	5.6	5.2	4.9	3.9
15 to 44 years	73,713	18,481	23,242	22,381	9,610	6.1	6.9	6.4	5.8	5.1
45 to 64 years	65,014	17,660	20,077	18,522	8,755	10.0	11.7	10.3	9.1	8.6
65 years and over	78,400	21,317	25,867	21,785	9,431	14.2	17.2	14.6	12.7	11.9
All ages ²	100,961	26,757	31,962	29,230	13,011	9.0	10.7	9.2	8.3	7.6
Under 15 years	11,595	2,839	4,129	3,465	1,162	5.2	5.7	5.5	5.0	3.8
15 to 44 years	24,610	6,138	7,319	7,705	3,448	7.3	8.7	7.3	6.9	6.4
45 to 64 years	31,028	8,750	9,355	8,818	4,105	10.0	12.0	10.2	9.0	8.5
65 years and over	33,693	9,023	11,153	9,223	4,294	13.5	16.1	14.0	12.2	11.6
Female (including deliveries):										
All ages ²	135,650	35,410	43,899	39,458	16,883	8.1	9.4	9.5	7.4	6.7
Under 15 years	8,371	1,995	2,736	2,666	974	4.8	5.5	4.7	4.8	4.0
15 to 44 years	48,934	12,300	15,862	14,636	6,135	5.7	6.3	6.1	5.3	4.6
45 to 64 years	33,817	8,872	10,662	9,639	4,644	10.0	11.5	10.4	9.1	8.6
65 years and over	44,501	12,241	14,629	12,505	5,126	14.8	18.1	15.2	13.2	12.1
Female (excluding deliveries):										
All ages ²	121,321	31,377	39,150	35,756	15,037	9.0	10.6	9.4	8.2	7.4
Under 15 years	8,318	1,985	2,720	2,643	971	4.8	5.5	4.7	4.8	4.0
15 to 44 years	34,685	8,286	11,135	10,969	4,295	6.5	7.2	7.0	6.1	5.3
45 to 64 years	33,789	8,863	10,657	9,628	4,640	10.0	11.6	10.4	9.1	8.6
65 years and over	44,501	12,241	14,529	12,505	5,126	14.8	18.1	15.2	13.2	12.1

¹ Includes data for which sex was not stated.² Includes data for which age was not stated.

Rate of discharges.—The rate, as well as the number, of discharges was higher for females than that for males. Including deliveries, the discharge rate for females was 165.8 per 1,000 population; excluding deliveries, the rate was 132.8. The discharge rate for males was 119.2 (table 1).

However, the highest rate of discharges (314.4) was among males 65 years of age and over. This was followed by a rate of 288.7 for females in the same age category. For both sexes combined the rate nearly doubled (300.8) that of the 45–64-year-age group (162.0, table 1). This ratio holds true for each region except the North Central where it slightly more than doubled for males in the age group 65 years and over. This region also had the highest rate (158.5) of total discharges. The West Region had the lowest rate (130.9) but was followed closely by the Northeast with a rate of 132.1 per 1,000 population (table 1).

With the exception of the age group 65 years and over, the second highest rate of discharges (213.0) was found among females 15–44 years of age and was primarily attributable to deliveries. This age group also had the most days of care for a single age-sex category (table 1).

Average length of stay.—When age is combined with sex, females under 45 years of age had a shorter average length of stay than did males in the same age bracket. But among those 65 years and over females had a longer length of stay than did males (table 1).

In all regions, females in the age group 15–44 years including those with deliveries had a shorter length of stay than did females in the same age group without deliveries. The Northeast Region's total average length of stay (9.9 days) was the longest of all the regions for all age-sex categories, whereas the West's was the shortest (7.1 days, table 1).

Average length of stay increased with age from 5 days for persons under age 15 to 14.2 days for persons aged 65 and over (table 1). This was true whether the patients were discharged alive or dead, except for the category "all other" patients discharged alive under 15 years of age (table 2). However, the average length of stay for patients discharged dead (14.8 days) was almost twice that for patients discharged alive (8.2 days).

Of patients discharged alive, all their patients averaged almost a half day longer stay (8.7 days) than did white patients (8.3 days). Within age groups, white patients 15–44 years of age stayed just over half a day less than all other patients in the same age group. For the remaining age groups, white patients stayed from 2.3 to 2.6 days less than all other patients in the same age groups.

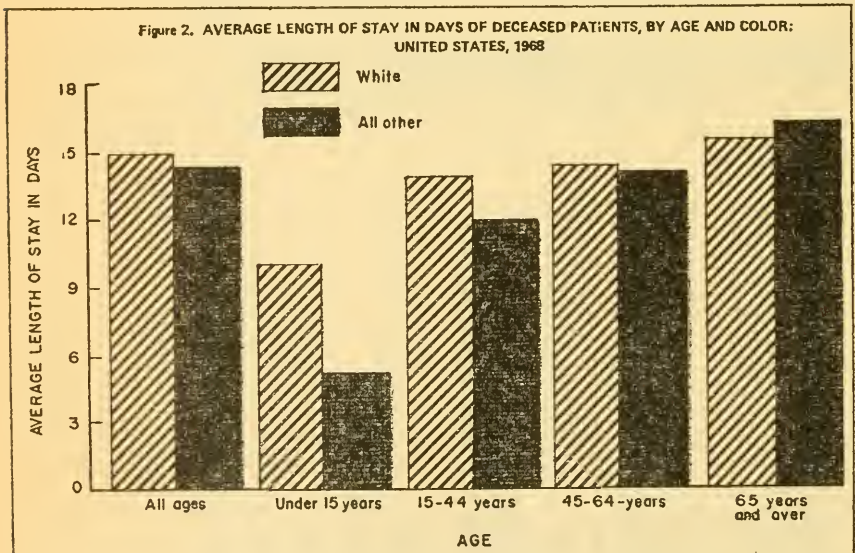


TABLE 2.—NUMBER OF PATIENTS DISCHARGED FROM SHORT-STAY HOSPITALS, DAYS OF CARE, AND AVERAGE LENGTH OF STAY IN DAYS, BY DISCHARGE STATUS, COLOR, AND AGE: UNITED STATES, 1968

[Excludes newborn]

Discharge status, color, and age	Number of discharges (thousands)	Days of care (thousands)	Average length of stay (days)
All discharges ¹	28,070	237,201	8.5
Under 15 years.....	3,988	19,999	5.0
15 to 44 years.....	12,036	73,713	6.1
45 to 64 years.....	6,517	65,014	10.0
65 years and over.....	5,520	78,400	14.2
Discharged alive ²	27,086	223,294	8.2
White ³	20,882	172,709	8.3
Under 15 years.....	2,962	14,137	4.8
15 to 44 years.....	8,873	53,498	6.0
45 to 64 years.....	5,030	48,753	9.7
65 years and over.....	4,011	56,277	14.0
All other.....	2,798	24,224	8.7
Under 15 years.....	460	3,299	7.2
15 to 44 years.....	1,586	10,528	6.6
45 to 64 years.....	466	5,753	12.3
65 years and over.....	285	4,640	16.3
Discharged dead ²	860	12,746	14.8
White.....	673	10,059	15.0
Under 15 years.....	14	142	10.0
15 to 44 years.....	42	592	13.9
45 to 64 years.....	171	2,471	14.4
65 years and over.....	444	6,892	15.5
All other.....	97	1,382	14.3
Under 15 years.....	6	29	5.2
15 to 44 years.....	13	160	11.9
45 to 64 years.....	33	468	14.1
65 years and over.....	45	724	16.3

¹ Includes data for which age, color, and/or discharge status was not stated.² Includes data for which color and/or age was not stated.³ Includes data for which age was not stated.

Among patients discharged dead, all other patients averaged more than half a day shorter stay (14.3 days) than did white patients (15.0 days). The most striking difference was among deceased patients under age 15; all other patients averaged a stay of 5.2 days while white patients averaged a stay of 10 days (table 2, fig. 2).

Diagnoses.—There was a total of 47.4 million diagnoses (table 4). Since each of the 28.1 million discharges had at least one diagnosis,² there were 28.1 million first-listed diagnoses (tables 3, 4). Therefore, the average number of diagnoses was 1.7 for each period of hospitalization. The largest single diagnostic category for both first-listed and all-list diagnoses was that for obstetrical conditions. Following this category the 10 most frequently recorded *first-listed* diagnoses, in descending order of magnitude for all age groups combined, are shown in table A.

By age groups, those 15–64 years of age showed digestive system diseases as the largest category of first-listed diagnoses. Diseases of the circulatory system, the highest first-listed diagnoses among the oldest age group, gradually decreased in frequency as age decreased. However, the reverse was true for injuries and other adverse effects. Within this category the largest number of discharge was among those under 45 years of age but decreased as age increased.

Nervous system and sense organ diseases were among the first five diagnoses for those under age 15 and for those over 65 years of age, but were not among the top five for those 15–64 years of age. Mental illness diagnoses were among the first six diagnoses in frequency only for those aged 15–44 years (table A).

When *all-listed* diagnoses were ranked, the first 10 were the same as those for first-listed diagnoses except that in three cases their rank order changed

² It appears reasonable to assume that in patients with multiple diagnoses the first-listed diagnosis was probably the primary cause of hospitalization.

slightly. Exclusive of obstetrical conditions, diseases of the digestive system remained as the most prevalent diagnoses of all discharged patients (table A).

Patients with a diagnosis of acute coronary occlusion had the longest average length of stay (18.8 days). The rank order for average length of stay by first-listed diagnosis is shown in table B.

TABLE A.—10 MOST FREQUENT CATEGORIES OF 1ST-LISTED AND ALL-LISTED DIAGNOSES EXCLUDING OBSTETRICAL CONDITIONS: RANK ORDER BY AGE, UNITED STATES, 1968

Diagnostic category	First-listed diagnoses						All-listed diagnoses	
	Rank order					65 years and over	Number in thou- sands	All ages (rank order)
	Number in thou- sands	All ages	Under 15 years ¹	15-44 years	45-64 years			
Digestive system.....	3,986	1	3	1	1	2	6,101	1
Respiratory system.....	3,272	2	1	4	6	5	4,881	4
Injuries and other adverse effects of chemical and other external causes.....	2,886	3	2	2	5	6	4,255	5
Circulatory system.....	2,669	4	(2)	7	2	1	5,973	2
Genitourinary system.....	2,647	5	4	3	3	7	5,070	3
Malignant and benign neoplasms.....	1,927	6	9	5	4	4	3,181	6
Nervous system and sense organs.....	1,542	7	5	9	7	3	2,823	7
Bones and organs of movement.....	1,080	8	8	8	8	9	2,043	9
Mental, psychoneurotic, and personality disorders.....	799	9	(2)	6	10	10	1,508	10
Allergies, endocrine system, metabolic, and nutritional diseases.....	785	10	10	10	9	8	2,337	8

¹ Congenital malformations ranked 6th and infective and parasitic diseases ranked 7th in this age group.

² This diagnosis was not among the first 10 for this age group.

TABLE B.—RANK ORDER OF AVERAGE LENGTH OF STAY IN DAYS FOR 7 FIRST-LISTED DIAGNOSES BY BODY SITE: UNITED STATES, 1968

Diagnostic site	Average length of stay in days, by rank order
Circulatory system: acute coronary occlusion.....	18.8
Nervous system and sense organs: Vascular lesions affecting central nervous system.....	16.6
Malignant and benign neoplasms: malignant.....	15.3
Genitourinary system: hyperplasia of prostate.....	14.1
Injuries and other adverse effects of chemical and other external causes: fractures.....	13.6
Bones and organs of movement: Arthritis.....	13.0
Displacement of intervertebral disc.....	12.9

TABLE 3.—NUMBER OF PATIENTS DISCHARGED FROM SHORT-STAY HOSPITALS, BY CATEGORY OF FIRST-LISTED DIAGNOSIS AND AGE: UNITED STATES, 1968

Excludes newborn. Diagnostic groupings and code number inclusions are based on the "International Classification of Diseases, Adapted," revised edition, December 1962, in thousands]

Diagnostic category	All ages ¹	Under 15 years	15-44 years	45-64 years	65 plus years
All conditions.....	28,070	3,988	12,036	6,517	5,520
Excluding obstetrical conditions.....	23,887	3,970	7,880	6,508	5,520
Infective and parasitic diseases (002-138).....	319	92	135	53	39
Malignant neoplasms (140-205).....	1,044	18	159	410	456
Benign neoplasms and neoplasms of unspecified nature (210-239).....	883	51	476	281	76
Allergic, endocrine system, metabolic and nutritional diseases (240-289).....	785	67	222	271	225
Hay fever and asthma (240-241).....	134	32	37	38	27
Diabetes mellitus (260).....	385	13	77	140	155
Diseases of blood and blood-forming organs (290-299).....	175	31	40	41	64
Mental, psychoneurotic, and personality disorders (300-329).....	799	30	432	244	93
Diseases of the nervous system and sense organs (330-398).....	1,542	232	261	386	662
Vascular lesions affecting central nervous system (330-335).....	504	8	20	120	356
Cataract.....	217	4	6	54	153
Diseases of the circulatory system (400-468).....	2,669	64	431	966	1,207
Acute coronary occlusion (420.1).....	372	(²)	27	168	176
All other diseases of the heart (400-420.0, 420.2-443).....	1,375	20	115	455	785
Hemorrhoids (with and without ulcer) (461).....	208	(²)	99	89	19
Diseases of the respiratory system (470-527).....	3,272	1,550	705	501	515
Acute upper respiratory infections (470-475).....	387	221	86	42	37
Hypertrophy of tonsils and adenoids (510).....	1,062	845	210	6	(³)
Pneumonia (all forms) (490-493).....	704	288	101	131	185
Diseases of the digestive system (530-587).....	3,986	535	1,367	1,247	836
Ulcer of stomach, duodenum, and gastrojejunal ulcer (540-552).....	445	6	157	179	103
Appendicitis (550-552).....	334	116	176	29	13
Inguinal hernia (560.0, 561.0).....	502	124	120	170	87
Gastroenteritis and colitis, except ulcerative (571).....	509	178	148	102	80
Cholelithiasis and cholecystitis (584-585).....	482	(²)	154	191	136
Diseases of the genitourinary system (590-637).....	2,647	238	1,288	698	422
Hyperplasia of prostate (610).....	191	(³)	2	55	134
Disorders of menstruation (634).....	396	4	282	100	9
Deliveries and complications of pregnancy, childbirth, and puerperium (640-689, Y06-Y07).....	4,183	18	4,156	9	(⁴)
Diseases of the skin and cellular tissue (690-716).....	388	66	160	101	61
Diseases of the bones and organs of movement (720-749).....	1,080	86	408	385	201
Arthritis (all forms) (720-725).....	263	7	44	108	105
Displacement of intervertebral disc (735).....	256	(²)	127	111	17
Congenital malformations (750-759).....	228	134	60	25	9
Injuries and adverse effects of chemical and other external causes (800-999, Y10.0).....	2,886	539	1,306	600	439
Fractures (all sites) (800-826).....	1,034	196	335	231	272
Laceration and open wound (870-898).....	347	61	213	57	16
All other conditions and special admissions (residual).....	1,185	238	430	300	216

¹ Includes data for which age was not stated.² Figure does not meet standards of reliability or precision.³ Quantity zero.⁴ Category not applicable.

TABLE 4.—NUMBER OF ALL-LISTED AND FIRST-LISTED DIAGNOSES, DAYS OF CARE, AND AVERAGE LENGTH OF STAY FOR PATIENTS DISCHARGED FROM SHORT-STAY HOSPITALS, BY CATEGORY OF FIRST-LISTED DIAGNOSES: UNITED STATES, 1968

Diagnostic category	Number of all-listed diagnoses	First-listed diagnoses		
		Number	Days of care	Average length of stay (in days)
All conditions	47,434	28,070	237,201	8.5
Excluding obstetrical conditions	42,890	23,897	220,026	9.2
Infective and parasitic disease (002-138)	572	319	3,147	9.9
Malignant neoplasms (140-205)	1,644	1,044	16,014	15.3
Benign neoplasms and neoplasms of unspecified nature (210-239)	1,537	883	5,960	6.7
Allergic, endocrine system, metabolic, and nutritional diseases (240-289)	2,337	785	8,158	10.4
Hay fever and asthma (240-241)	228	134	1,108	8.3
Diabetes mellitus (260)	1,204	385	4,719	12.2
Diseases of blood and blood-forming organs (290-299)	648	175	1,872	10.7
Mental, psychoneurotic, and personality disorders (300-329)	1,508	799	9,760	12.2
Diseases of the nervous system and sense organs (330-398)	2,823	1,542	17,011	11.0
Vascular lesions affecting central nervous system (330-334)	847	504	8,364	16.6
Cataract (385)	257	217	1,736	8.0
Diseases of the circulatory system (400-468)	5,973	2,669	33,961	12.7
Acute coronary occlusion (420.1)	442	372	7,001	18.8
All other diseases of the heart (400-420.0, 420.2-443)	3,596	1,375	16,874	12.3
Hemorrhoids (with and without ulcer) (461)	316	208	1,479	7.1
Diseases of the respiratory system (470-527)	4,881	3,272	20,459	6.3
Acute upper respiratory infections (470-475)	597	387	2,204	5.2
Hypertrophy of tonsils and adenoids (510)	1,093	1,062	2,351	2.2
Pneumonia (all forms) (490-493)	1,023	704	6,880	9.8
Diseases of the digestive system (530-587)	6,101	3,986	32,868	8.2
Ulcer of stomach, duodenum, and gastrojejunal ulcer (540-542)	627	445	4,762	10.7
Appendicitis (550-552)	371	334	2,278	6.8
Inguinal hernia (560.0, 561.0)	580	502	3,590	7.2
Gastroenteritis and colitis, except ulcerative (571)	641	509	2,634	5.2
Cholelithiasis and cholecystitis (584-585)	640	482	5,327	11.0
Diseases of the genitourinary system (590-637)	5,070	2,647	19,053	7.2
Hyperplasia of prostate (610)	338	191	2,685	14.1
Disorders of menstruation (634)	519	396	1,793	4.5
Deliveries and complications of pregnancy, childbirth, and puerperium (640-689, Y06-Y07)	4,545	4,183	17,175	4.1
Diseases of the skin and cellular tissue (690-716)	728	388	3,243	8.4
Diseases of the bones and organs of movement (720-749)	2,043	1,080	11,181	10.4
Arthritis (all forms) (720-725)	732	263	3,434	12.0
Displacement of intervertebral disc (735)	323	256	3,296	12.9
Congenital malformations (750-759)	412	228	2,127	9.3
Injuries and adverse effects of chemical and other external causes (800-999, Y10.0)	4,255	2,886	27,084	9.4
Fractures (all sites) (800-826)	1,244	1,034	14,100	13.6
Laceration and open wound (870-898)	548	347	1,963	5.7
All other conditions and special admission (residual)	2,356	1,185	8,130	6.9

[Excludes newborn. Diagnostic groupings and code number inclusions are based on the international classification of diseases, adapted, revised, edition, December 1962; in thousands]

Source of Data

The Hospital Discharge Survey collects data on patients discharged from noninstitutional short-stay hospitals located in the 50 States and the District of Columbia. This report excludes discharges for all Federal hospitals and newborn infants. Information for this report was obtained from a national sample of approximately 400 hospitals which furnished data on slightly over 210,000 medical abstracts of hospital discharges.

Sampling Errors

The estimates presented are subject to sampling error since a sample rather than the entire population has been surveyed. The standard errors appropriate for the estimates of the number of discharges are shown in table I and those for days of care are shown in table II.

Rounding

Due to rounding, detailed figures within tables may not add to totals. However, all rounded numbers are obtained from computations done on unrounded numbers.

Definitions

Short-stay hospitals are general and short-term special hospitals that have six beds or more for inpatient use and an average stay of less than 30 days.

A *patient or inpatient* is a person who has been formally admitted to the inpatient service of a short-stay hospital for observation, care, diagnosis, or treatment.

A *discharge* is the formal release of an inpatient by a hospital, that is, the termination of a period of hospitalization by death or by disposition to place of residence, nursing home, or another hospital. Total discharges could include more than one period of hospitalization for any one patient, but no distinction is made between one and more than one hospital episode per patient. "Discharges" and "patients (or inpatients) discharged" are used synonymously.

TABLE I.—*Approximate standard errors of estimated numbers of discharges*

<i>Size of estimate</i>	<i>Standard error</i>
6,000 -----	1, 290
10,000 -----	1, 680
50,000 -----	4, 080
100,000 -----	6, 290
500,000 -----	21, 300
1,000,000 -----	39, 300
5,000,000 -----	182, 500
10,000,000 -----	361, 000
30,000,000 -----	1, 077, 000

TABLE II.—*Approximate standard errors of estimated numbers of days of care*

<i>Size of estimate</i>	<i>Standard error</i>
500,000 -----	104, 900
1,000,000 -----	148, 800
5,000,000 -----	341, 500
10,000,000 -----	497, 000
50,000,000 -----	1, 350, 000
100,000,000 -----	2, 260, 000
200,000,000 -----	4, 000, 000
300,000,000 -----	5, 730, 000

Discharge rate is the ratio of the number of hospital discharges during a specified year to the number of persons in the civilian, noninstitutional population as of July 1 of the specific year. Rates in this report are given for 1,000 persons in the population.

Days of care denotes the unit of measure for lodging facilities provided and services rendered to an inpatient between two successive dates (admission and discharge). A stay of less than 1 day (admission and discharge on the same calendar day) is counted as 1 day in the summations of inpatient days.

Average length of stay is the total number of inpatient days accumulated by patients at time of discharge from short-stay hospitals during a specified calendar year divided by the number of patients discharged.

First-listed diagnoses are the aggregate of individually coded diagnoses listed in position number 1 on the face sheet of the medical records for patients discharged, including single (only) and first of multiple discharge diagnoses.

All-listed diagnoses are the aggregate of individually coded diagnoses listed in all positions on the face sheet of the medical records for patients discharged, including single and all multiple discharge diagnoses. The maximum number for one hospitalization period is five.

Color is designated as either "White" or "All other." In 12.4 percent of the medical abstracts no designation was made.

Obstetrical conditions include deliveries, abortions, and complications of pregnancy, childbirth and puerperium.

Deliveries include deliveries with and without mention of complications.

Discharge status is the condition (i.e., either alive or dead) of a patient when discharged.

DISCHARGES FROM SHORT-STAY HOSPITALS WITH NEOPLASMS¹ BY LENGTH OF STAY INTERVALS BY AGE,
UNITED STATES: 1968, (EXCLUDING NEWBORN)

[Number of discharges in thousands]

	All ages	Less than 65 years	65 and over
Malignant neoplasms:²			
Total.....	1,045	587	456
Less than 1 day.....	12	7	5
1 day.....	43	28	15
2 days.....	66	42	23
3 days.....	62	38	24
4 days.....	56	36	20
5 to 7 days.....	145	85	60
8 to 14 days.....	284	16	118
15 to 21 days.....	152	79	74
22 to 30 days.....	102	48	54
31 and over.....	123	59	63
Benign neoplasms and neoplasms of unspecified nature:³			
Total.....	883	807	75
Less than 1 day.....	15	14	(4)
1 day.....	46	43	3
2 days.....	166	155	11
3 days.....	116	108	8
4 days.....	70	64	6
5 to 7 days.....	169	153	16
8 to 14 days.....	242	226	17
15 to 21 days.....	38	31	7
22 to 30 days.....	14	8	5
31 and over.....	7	5	2

¹ First-listed diagnosis.

² International classification of diseases adapted revised 1962 edition. Codes 140.-205.0.

³ Ibid., Codes 210.-239.9.

⁴ Less than 1,000.

Source: Hospital Discharge Survey, Provisional Data, National Center for Health Statistics, June 1972.

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT FOR YEAR 1971

MADE BY AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

Date of filing: This exhibit is required to be filed not later than June 30, 1971

Form No. and name of policy	Premiums earned	Losses incurred	Loss ratio (per-cent)	Commissions incurred	Rate of commission and expense allowance (per-cent)	Dividends incurred
A. GROUP AND CERTAIN INDIVIDUAL POLICIES						
Group.....	\$430,322.35	\$64,330.99	15	\$117,052.89	27.2	None
Conversions.....	1,808.29	1,860.96	103	38.26	2.1	None
Premiums \$7.50 or less per person annually.....						
HC-5 Cancer policy.....	168,239.27	114,950.28	68		4.0	
HC-45 Cancer policy.....	87,196.30	55,927.60	64		5.7	
HA-500 Holiday accident policy.....	45.72	0.00	0		0.7	
Subtotal.....	687,611.93	237,069.83	34	128,793.76	18.7	None
B. HOSPITAL, MEDICAL AND SURGICAL POLICIES						
Collectively renewable.....						
FMS-100 Franchise medical-surgical.....	199.48	216.00	108		0	
HFG-60 Franchise group policy.....	2,165.65	2,486.30	115		2.1	
FHG-43 Franchise group policy.....	3,558.05	2,180.30	61		8.3	
Subtotal.....	5,923.18	4,882.60	82	342.32	5.8	None
Guaranteed renewable.....						
HAP-100 automatic protector.....	59,173.38	57,503.85	97		2.0	
HFP-60 family protector.....	32,676.14	35,137.38	108		1.5	
HFP-50 family protector.....	1,680.74	3,342.00	199		1.8	
FP-61 hospital policy.....	756.98	56.00	7		2.5	
FP-50-1 hospital policy.....	2,583.68	2,780.95	108		3.3	
THP-1 hospital policy.....	1,693.35	611.01	36		4.3	
AFL-P9 hospital policy.....	52,021.08	38,306.47	74		4.7	
AHB-100 hospital policy.....	69,018.16	47,608.75	69		10.7	
HAP-101 hospital policy.....	22,449.56	26,209.10	117		4.5	
AHB-65 hospital policy.....	846.02	887.99	105		3.9	
HFG-60-1 hospital policy.....	87.00	0.00	0		0.0	
AFL-P10 hospital policy.....	379,247.87	349,209.80	92		5.1	
HLS-100 hospital policy.....	259.42	129.00	50		0.0	
NAM-100 hospital policy.....	99,004.27	86,804.48	88		6.2	
PEC-1 hospital policy.....	17,196.53	14,131.50	82		6.1	
AFL-P54 hospital policy.....	63,827.00	39,166.91	61		5.9	
HC-100 hospital policy*.....	795.13	2,500.68	329		4.7	
HRB-59 hospital room benefit policy*.....	5,280.48	2,287.00	43		7.6	
PEC-62 hospital policy*.....	24,824.74	17,450.50	70		5.7	
HAP-63 hospital policy*.....	7,827.95	10,686.30	137		5.1	
HRB-100 hospital room benefit policy*.....	7,943.80	9,233.00	116		6.0	
AFL-P11 hospital policy*.....	3,196.16	2,767.00	87		8.2	
AFL-P73 hospital policy.....	309,332.87	189,103.41	61		9.0	
PEC-64 hospital policy*.....	195.24	162.00	83		5.0	
MM-77 major expense hospital and surgical.....	542,484.10	447,274.88	82		7.2	
WP-78 hospital policy.....	746,930.02	483,725.39	65		6.7	
MSP-100 medical-surgical policy*.....	4,410.46	2,535.00	57		6.4	
FP-40 hospital policy*.....	16,137.53	25,184.58	156		4.9	
LH-100 hospital policy*.....	1,551.75	2,231.00	144		5.0	
HSP-40 hospital policy*.....	1,147.15	1,117.00	97		4.2	
HSW-43 hospital policy*.....	47,469.20	48,219.11	102		6.0	
HSM-41 hospital policy*.....	472.20	1,645.13	348		0.0	
HSM-42 hospital policy*.....	32,246.55	30,708.62	95		3.1	
MST-98 medical-surgical policy.....	28,232.60	8,513.40	30		20.2	
HREP-A3 hospital room expense policy*.....	874.12	290.00	33		8.1	

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT FOR YEAR 1971

MADE BY AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

Date of filing: This exhibit is required to be filed not later than June 30, 1971

Form No. and name of policy	Premiums earned	Losses incurred	Loss ratio (per-cent)	Commissions incurred	Rate of commission and expense allowance (per-cent)	Dividends incurred
B. HOSPITAL, MEDICAL AND SURGICAL POLICIES—Continued						
Guaranteed renewable—Continued						
HREP-A4 hospital room expense policy	39,788.20	15,705.00	39		14.6	
HREP-A6 hospital room expense policy*	99.02	0.00	0		0.0	
MCS-A5 medicare supplement	31,443.94	7,451.00	24		6.5	
SC-A6 senior citizens policy*	2,395.34	6,732.15	281		5.8	
AHB-101 disability benefit for hospital confinement	109,593.54	58,367.68	53		25.9	
MM-H2 major expense hospital and surgical policy	415,925.32	134,533.73	32		36.5	
WP-H3 hospital policy	222,286.12	57,038.12	26		33.2	
MCS-H4 medicare supplement	43,874.35	12,070.00	28		36.0	
A-4739 hospital indemnity policy	923,555.03	414,308.42	45		5.0	
HIC-4 hospital intensive care policy	67,193.05	10,007.00	15		81.5	
Subtotal	4,440,031.54	2,703,732.29	61	552,223.41	12.4	None
All other:						
HGS-150 golden shield*	126.88	0.00	0		4.5	
DRB-100 hospital indemnity policy*	734.15	539.00	73		6.8	
DRB-125 hospital indemnity policy*	162.67	117.00	72		8.7	
Subtotal	1,023.70	656.00	64	70.00	6.8	None
C. LOSS OF TIME POLICIES						
Guaranteed renewable						
SP-75 salary protector*	371.22	(58.00)	-16		3.4	
Sp-100 salary protector	8,420.57	2,022.02	24		7.9	
FISP-100 field issue salary protector	6,631.79	3,248.02	49		20.3	
Subtotal	15,423.58	5,212.04	34	2,027.02	13.1	None
D. ALL OTHER POLICIES						
Guaranteed renewable						
AHP-100 auto accident and limited hospital policy*	25,232.61	10,140.73	40		4.9	
AHP-200 auto accident and limited hospital policy	52,546.19	7,917.36	15		32.3	
FIC-1 field issue cancer policy	8,301,302.63	3,377,674.05	41		22.4	
FIC-2 field issue cancer policy	836,381.07	252,785.69	30		29.3	
FIC-30M field issue cancer policy	1,197,521.92	280,140.38	23		44.0	
CHI-2 cancer policy	95,948.15	20,738.90	22		39.9	
HC-6 cancer policy*	74,153.81	54,869.80	74		5.0	
HC-9 cancer policy*	57,333.45	38,112.67	66		5.8	
HC-55 cancer policy*	153,318.04	122,596.98	80		7.1	
HC-57 cancer policy*	27,384.04	24,147.50	88		5.8	
HC-66 cancer policy*	247,245.36	136,553.30	55		6.4	
HC-C5 cancer policy*	134,633.99	56,594.90	42		6.4	
A-3415 increased benefits rider*	1,314,751.29	638,036.55	49		5.5	
LC-10 lung cancer policy*	376.67	(288.00)	-76		3.7	
HC-10 cancer policy*	1,084.55	1,223.00	113		0.0	
HC-99 cancer policy*	162,212.28	53,568.93	33		6.4	
A-4474 cancer care policy	4,389,240.77	290,838.55	7		89.8	
Subtotal	17,070,666.82	5,365,651.29	31	6,661,646.28	39.0	None
Total direct business	22,220,680.75	8,317,204.05	37	7,345,102.79	33.0	None
Reinsured assumed less ceded	694,114.76	193,817.26	18	52,978.13	65.3	None
Totals	22,914,795.51	8,511,021.31	37	7,798,080.92	34.0	None

Note: Number of accident and health policies in force at end of year: group certificates, 14,069; collectively renewable, 73; noncancellable, none; guaranteed renewable, 789,940; nonrenewable for stated reasons only, none; other accident only, none; all other, 23.

AMERICAN FAMILY LIFE
ASSURANCE CO., OF COLUMBUS,
Columbus, Ga., June 9, 1972.

HON. PHILIP A. HART,
U.S. Senate, Washington, D.C.

DEAR SENATOR HART: The press, and probably the public, has assumed as a result of our voluntary cooperation with your Committee and staff in its search for facts relative to the role of insurance companies in policing the delivery of hospital and medical care that our Cancer Care insurance itself was the subject of your investigation.

This probably results from reckless, illfounded and totally misleading statistics cited to your Committee by Herbert Denenberg, Commissioner of Insurance for the Commonwealth of Pennsylvania. Prior to these hearings our company chose to contest a certain arbitrary order of the Pennsylvania Commissioner in the Courts of that State. He was so patently wrong that we won the case, and he has not as yet seen fit to file a notice of appeal. He is still smarting under that defeat.

His testimony before your Committee was not only biased but was knowingly and intentionally misleading. Denenberg hails himself as expert in the whole field of insurance—and when an expert knowingly takes an isolated statistic and presents it as representative of the end result—depending upon his expertise, position and reputation for credibility he has intentionally lied.

I assert that one Herbert Denenberg lied before your Committee in his testimony on May 11, 1972. He lied when he cited the isolated statistic that our company had returned to Pennsylvanians only 7% of premiums collected in benefits. The knowing omission of ultimate facts is just as gross as the express falsification of fact. This insurance expert lied not in what he told your Committee but in what he did not tell your Committee and in what he led you to believe.

He did not tell your Committee that cancer hospital insurance is not like general, all purpose hospital insurance. In the latter case it can be expected that some member of the family group will for some reason be hospitalized every 12, 24 or 36 months as a result of accident, influenza or even a virus—but cancer, like lightning, strikes not often. It will strike one out of four Americans—not necessarily this year, next year, or even ten years from now, but over the entire lifetime of the populace.

When the Commissioner of Pennsylvania said we had paid out 7¢ out of the dollar, he knowingly failed to tell you we had been doing business in Pennsylvania only 19 months and that our volume of sales in that state in such a short period were such that they could not possibly be indicative of the final results. It takes a new life insurance company something like 35 years for its death claims paid to level out. They know in the outset that everyone they insure will ultimately die and end up as a claimant—but they insure only those that they consider have many healthy years ahead. They plan to collect premiums for many years, invest those premiums so that they will have the funds on hand to pay the death claim when that inevitable day arrives. Until death of the insured they pay out nothing, and on the basis of blocks of persons insured in any given year, the insurance company starts out with a nil payout and slowly progresses until the insureds reach old age and they have to dip into the reserves that have been built up through the years to make ends meet.

If you drop your life insurance policy, you have paid dearly for short term protection because you have paid the selling, underwriting and issue cost for a lifetime. But, if you keep your policy in force, this cost is spread over the remainder of your life and becomes insignificant in relation to the benefits paid. The exact same is true of cancer insurance, except that only one in four insureds will collect and the premiums are calculated accordingly.

There is one other difference and that is mortality tables. Life insurance has been with us for more than a century and rates are based on known mortality statistics. Cancer has been with us, as has death, since the beginning of time, but we have been offering cancer policies only since 1958. There is a great unknown. We pay limited benefits during the first 90 days of hospitalization, but after 90 days we assume the whole hospital-medical tab to the limit of \$5,000 per month—to maximum of \$50,000 per insured. While we reserve the right to raise rates we know as a practical matter this is no solution, because a raise in rates results in a lapse by the healthy while the claimants keep their policies in force.

Certainly we want to make a profit, but first and foremost we want to be and stay in financial condition to meet our obligations to policyholders. Our rates are now calculated to do both—but, if one must go—profits will be the first to go, then stockholders investment and equity, and the last dollar this company possesses will be paid to an insured cancer victim.

We have been definitely damaged by the irresponsible and maliciously inspired conclusions espoused by Denenberg—especially in the Washington area where we insure many thousands of government employees. His conclusions have been parroted, unchecked by Federal Administrator of Insurance Bernstein and even by a government employee in a letter to your Committee—the contents of which were revealed to the press but not to me—even though I was a voluntary witness.

I would appreciate you making this letter a part of the official record of the hearing of your Committee of June 7, 1972.

Respectfully yours,

JOHN B. AMOS.

[From the Washington Post, June 8, 1972]

PENTAGON HEALTH PLAN CRITICIZED

INSURANCE FIRM UNDER U.S. PROBE

(By Bob Woodward)

The Department of Defense's welfare and recreation association has promoted health insurance sold by a company being investigated by the Senate Subcommittee on Antitrust and Monopoly.

In testimony yesterday before the Subcommittee, chaired by Sen. Philip A. Hart (D-Mich.), a letter was read from Francine Davis, a secretary for 29 years in the Office of the Secretary of Defense at the Pentagon, complaining about the promotion of a company that retains between 58 and 93 per cent of the premiums it collects.

"When federal government employees are sucked in on a thing like this, how can we believe anything else?" Mrs. Davis asked in a letter last week to Sen. Hart.

A spokesman for the Defense Department recreation association acknowledged yesterday that it has distributed literature for the American Family Life Assurance Co., but could not say who made the decision.

John B. Amos, president of the company, told Hart's Subcommittee yesterday that his company was paying back between 7 and 42 cents on each dollar collected in premiums.

By contrast, Blue Cross health insurance plans return more than 97 cents in benefits on each premium dollar, according to earlier testimony before the Subcommittee.

The promotion was done in a letter sent by a former recreation association president to all Defense Department agencies asking them to distribute the literature on the policies.

In an interview after the hearing, Amos told a reporter that about 25,000 federal employees have policies with his firm. He said many of them were sold through promotions by various federal welfare associations, which several officials described as being, in effect, adjuncts of personnel departments.

American Family sells the so-called "cancer" policy, in which the company pays hospital and doctor bills for a subscriber who suffers cancer.

The cost of the policy runs from \$24 to \$48 a year, depending on the number of people in the family.

According to the Subcommittee staff, American has sold many of the cancer policies to federal employees because it was offered through a government recreation association.

"I just figured that the company knew what they were doing when I got a letter through the personnel office saying it was a good deal," Mrs. Davis, a secretary in the Defense Department, said yesterday in an interview.

"Now I'm amazed that the government got hooked into it," she said.

Spokesmen at the Pentagon denied that the promotion was done through the personnel office.

However, Jerome S. Antel Jr., president of the League of Federal Recreation Associations, said the various federal welfare and recreation associations "are generally one and the same as the personnel departments."

At the Pentagon yesterday no one was sure who was responsible for promoting the American cancer health insurance policies.

Frederick A. Dion, the former president of the Pentagon recreation association, signed the letter in October 1970. Dion could not be reached for comment yesterday because he was on annual leave, according to his secretary.

Vernon J. Dwyer, the current president, said yesterday that he knew nothing about the decision to distribute the literature.

"It was not intended as an endorsement," he said. However, he said that in the future the association would take a "broad look" at all such promotions.

Gene Hodges, chief of health benefits in the Pentagon personnel department, said: "I'm sure it would have been investigated by the welfare and recreation association before they sponsor something . . . most responsible people do a little investigating."

Pennsylvania's crusading insurance commissioner, Herbert S. Denenberg, told the Subcommittee last month that the mass-marketed health policies are "junk" and "nothing short of fraud."

Denenberg singled out the American cancer policies, which he said return only 7 cents on the premium dollar in Pennsylvania.

"You can do better with the Pennsylvania lottery that returns 45 percent," Denenberg said.

Yesterday, Amos, the president of American Family, told the Subcommittee that Blue Cross and other general health insurance firms are attempting to drive his company out of business.

Amos said that the larger companies were doing this through agreements not to pay double benefits to persons with two policies. In addition, he said that the companies refuse to pay claims to persons receiving benefits from his firm.

"Thus, it can be seen that they (subscribers) are coerced and intimidated into not subscribing to our plan, and we have been boycotted and a market closed to us," Amos said.

Though Amos acknowledged that his company returns as little as 7 cents on the premium dollar, he said that as his firm's subscribers get older and become ill with cancer, the amount of return would increase.

Mr. AMOS. Is it something I wrote?

Mr. SHARP. Would you like me to read the letter to you?

Mr. AMOS. I'd like to see it.

Mr. HART. This is another—this is a communication from a third party.

Mr. AMOS. Oh.

Mr. SHARP. This is a communication by a Virginia resident to Senator Hart, a letter dated June 1, 1972. We'd be glad to supply you with a copy.

Mr. AMOS. No, that's all right. I thought it was one that I had written, and I didn't remember one.

Mr. SHARP. No, I'm sorry. It's not. I had one more question, is it all right?

Mr. HART. Yes, sir.

Mr. SHARP. In your statement you said that the "writers of special risk insurance, such as ourselves, cannot compete with carriers selling broad-based coverage, to the extent that the broad-base insurance contains, as it almost always does, COB provisions. The COB provisions, when applied, eliminate the utility of special risk policies."

Mr. AMOS. Right.

Mr. SHARP. In other words, I take it that despite your comments earlier in the statement that "group medical care insurance often has notable exceptions and limitations, employers apparently feel that the coverage they provide is good enough so that they don't need a supplemental coverage." Why would the elimination of COB, coordination of benefits, help the sale of your policies?

Mr. AMOS. I can answer that. When they drafted COB, they set up this order of payment between two group carriers, and then they said at one of their meetings or exchange of memorandum, that this thing wasn't tight enough, that we've got to put some teeth in it, so that the insurance companies of this Nation who are selling health insurance, will either get in this consortium or get out of the insurance business.

And they put one more provision. And they said if you do not have a COB provision in the other policy, the other policy shall pay first in all events.

Consequently, loopholes and whatnot have nothing to do with it. If you've got a \$1,500 claim against Blue Cross and I owe you \$1,000 under my policy, they're going to take the full \$1,000 off the Blue Cross plan and they're going to pay you \$500.

So, all you've done is bought Blue Cross a reinsurance contract with your own money, and paid for it.

Mr. SHARP. Why would the employer object if your policy would pay first?

Mr. AMOS. The employer doesn't want his people to buy things that they're not going to get anything for.

Mr. SHARP. Well, don't they have—in a group comprehensive policy with a group carrier, don't they have regular clauses of loss on all of these policies?

Mr. AMOS. Maybe, maybe not.

Mr. SHARP. Let's assume they do.

Mr. AMOS. Well, so what? That is not my problem with getting payroll deductions. My problem in getting payroll deductions is that the employer says, "I don't want my people buying insurance for Blue Cross or for Travelers because if they buy this, they're never going to get a dime. Everything you pay them is going to be deducted from what they would get anyway."

Mr. SHARP. We've heard a lot about "tailormaking policies" here. Couldn't they "tailor make" a supplemental coverage to take care of the doctor bills for coinsurance, and noncovered items, as is done with medicare, so that it will be no overlap, and the COB question will be rendered moot?

Mr. AMOS. No. It's possible, but I believe in the overlap.

Mr. SHARP. Pardon me?

Mr. AMOS. I believe in the overlap. I find nothing wrong morally with a man taking home a dollar from his hospital policy and paying for his mother-in-law to fly to California to be with his children while his wife's in the hospital.

We had a case in our home office within the last 2 months where Occidental paid, I believe, \$7,200 on an \$8,300 bill. Our little cancer policy paid \$2,000. It was a brain tumor. The lady stayed in the hospital for almost a month, had a baby 3 days before the brain tumor operation, a brandnew baby. And they had to send for relatives all over the United States to help take care of him. Now, that boy didn't make any profit even though he walked off with \$400 or \$500 in cash, which he could start paying out.

Mr. SHARP. Thank you very much, Mr. Amos.

Mr. HART. Mr. Chumbris.

Mr. CHUMBRIS. Thank you, Mr. Chairman.

Mr. Amos, you've been testifying about cancer insurance. We've heard witnesses testifying about supplemental insurance. We've heard witnesses testify about a regular health insurance, whether it's individual or group, and there's much talk about the type of insurance being afforded to the consumers.

Of course, much of it has happened—a lot of it has happened, let's say, since 1965, when high hospital cost became a key issue.

And, as I related earlier, \$46 a day, per day cost in 1965 prior to medicare and minimum wage and other things, today, is running over \$100 a day.

So, everybody is more conscious of the cost to him if he or someone in his family becomes ill. And he's looking at these various types of policies that we're discussing here.

I can understand when a lawyer who is 35 to 45 years—who is 35 years of age, and he's offered a group insurance that will pay him \$25 per day on a basis of \$40 a year—in 10 years he'll pay out \$400.

That means if he goes to the hospital only 16 days during that 10-year period, he breaks even with that \$400 that he's paid out during that 10-year period.

So, the fellow says, "Well, I've got a chance to go to the hospital that many days in the next 10 years, so it's worth it for me to go ahead and buy this supplemental policy to take care of the additional cost."

Now, of course, the older you get, the higher it gets, but—so you come along with your cancer policy and somebody looks at it from that point of view and says, "Well, if this ever hits me or a member of my family, it's going to wipe me out. So, maybe I'll just gamble and pay so much a year, just like you pay for your automobile insurance or your fire insurance on your house."

But all of these things have become prevalent today because of the fact that we no longer are in the era when you used to pay \$10 a day for a hospital. And that wasn't too long ago that you'd pay \$10 a day for a hospital bed.

Today, if you live in Philadelphia, according to testimony the other day, it's \$192 a day in Philadelphia. Of course, it's not that high in Durham N.C., but it's \$55 a day when I was down there a year ago—a year and a half ago in Durham, N.C., for a hospital per day.

So the thing I think we have to wrestle with is this question of how high is that hospital bill going to be.

If it gets higher, that will probably bring more insurance plans that will be offered as supplemental or special type of insurances, which is going to put this subcommittee and other committees of Congress to work to see if these insurance companies that are being presented to the public are legitimate policies.

I think that's the main concern. If the policies are legitimate, if the price is within reason, and if it gives the coverage that the people are led to believe that it's going to give, I don't think anybody's going to quarrel with it.

But I think one of the main problems we've got to concern ourselves with, and I think we've sort of lost sight of it in our hearings during this particular turn, and this is what is the patient, what is the doctor, what is the hospital, what is the insurer, whether he is group health or whether he is Blue Cross or whether he is a commercial insurer, and

what is the Government itself doing with its medicare program and its medicaid program which have created some of these problems?

And if each does their job 100 percent, perhaps maybe we won't have to worry about \$200 a day hospital bills, or \$300.

But maybe this \$100 a day that we're talking about in this particular area can be reduced maybe \$20 or \$30 a day, and at least we can not have to look forward to more special types of policies to supplement what policies we already have.

Mr. AMOS. Counsel, I agree with you 100 percent, but we also have got to remember that the hospital industry was probably further behind the times in this affluent society of ours from a wage standpoint, when we started out.

I checked before leaving home, and I found out that in 1966, Medical Center started an orderly off at \$120 a month. Today they start him off at \$341 a month plus 10 percent for so-called fringe benefits. I disagree with that term totally.

That's my money. I worked for it. Nobody has ever given me anything. And I——

Mr. CHUMBRIS. That's why——

Mr. AMOS. I don't believe any employer has ever given his employees anything in fringe benefits.

Mr. CHUMBRIS. That's why I prefaced my remarks with "prior to medicare and the minimum wage, and before it became applicable to hospitals."

Mr. AMOS. We've still got someway to go because at \$341 a month plus \$34 in fringe benefits, that man, if he's got three children, living in Columbus, Ga., whether he be black or white, has got to moonlight to make a living for his family, or his wife has got to work full time too.

Mr. CHUMBRIS. Thank you. I have no further questions. I believe Mr. Kern does.

Mr. HART. Yes, Mr. Kern.

Mr. KERN. Mr. Amos, I would just like to raise two points, Mr. Denenberg claimed that in the State of Pennsylvania, that your loss ratio was only 7 percent, that is in dollars paid out to claims as a percentage of premiums for that, is that right?

Mr. AMOS. That's correct, that's what he said.

Mr. KERN. Now, in your statement here, on the last page, you state that your loss ratio in policy year one is 16 percent and in policy year two it's 30 percent.

Mr. AMOS. Correct.

Mr. KERN. Now, as part of your reply to Mr. Denenberg, you said, we've been in business now there for 19 months.

Mr. AMOS. Now, the explanation is that with 1,500 policies one year and 6,000 the next, you do not have a sample, an accurate sample to reach your average.

Mr. KERN. So, you think if you were writing more policies there that it would be more nearly approximately 16 percent, 30 percent?

Mr. AMOS. Exactly. Exactly. Now, this number of policies, for instance, the 1,500 policies, two major claims could have run it to 20 percent or 50 percent. So, you have to be dealing in large numbers to get accuracy, accurate averages in insurance.

Mr. KERN. One more point. You state also that you've been writing cancer insurance, I believe for 14 years?

Mr. AMOS. Since 1958.

Mr. KERN. Right. And again, in this loss ratio table you give the firm figures only for 4 years out of those 14, and from then on its projections. Is that again because of an insufficiency of a sample?

Mr. AMOS. It wasn't—that's part of it, but I, in other words, don't believe we'd have been accurate. But also, we didn't have it on the computer.

We had to go back to the claim and everything and separate various types of business out of the general accident health, because we write a little bit of general accident and health, and a declining amount percentage-wise.

And in those earlier years we had more accident and health mixed in with cancer, to where you couldn't draw your cancer business out of it.

Mr. KERN. One final question. Has your company ever done anything in the nature of trying to educate the public about the dangers of cancer, that is affirmatively, not simply as part of an insurance—

Mr. AMOS. Yes, sir; my company has done something I'm very proud of. In 1953 we instituted a program in conjunction with Dr. Davis at Johns Hopkins.

He had developed what was a whole Pap smear test. We made this test available upon request to all female policyholders at no cost to them. We hired a pathology lab to run those tests, and we were forced to discontinue it after 6 or 7 years and after several, several positive findings, by disgruntled physicians who claimed that we were practicing medicine and injecting ourselves between them and their patients, and by the possibility of action, you know, tort action in the event something went wrong with the lady after the event.

Not that there was any danger, but we could have still had—say that she took the thing and had a miscarriage later. And we finally concluded that it wasn't worth the trouble that we were going to. And that—

Mr. KERN. Thank you.

Mr. AMOS. It never cost our policyholders a penny, but it cost the company thousands of dollars during the time the program went on.

Mr. HART. Mr. Amos, thank you very much. We adjourn, to return in this room tomorrow at 10.

Mr. AMOS. Thank you so much, Senator, gentlemen.

(Whereupon, the hearing concluded at 3:20 p.m., to resume at 10 a.m. the following day.)

HEARINGS ON COMMERCIAL HEALTH AND ACCIDENT INSURANCE INDUSTRY

THURSDAY, JUNE 8, 1972

U.S. SENATE,
SUBCOMMITTEE ON ANTITRUST AND MONOPOLY,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met at 10 a.m., in room 2228, New Senate Office Building, Senator Philip A. Hart presiding.

Present: Senators Hart, Hruska, and Gurney.

Also present: Howard O'Leary, chief counsel; Peter N. Chumbris, minority counsel; Charles Kern, staff of Senator Fong; Dean E. Sharp, assistant counsel; Patricia Bario, editorial director and Janice Williams, clerk.

Senator HART. The committee will be in order.

This morning, the committee will have the benefit of testimony from the chairman of the board of Mutual of Omaha. When an official from General Motors appears in front of this committee I take pride in presenting him, I suspect Senator Hruska feels the same way about it.

Senator HRUSKA. I do, Mr. Chairman.

I should like to welcome Mr. Skutt and members of his organization.

Mr. Chairman, you should know that in Omaha and in Nebraska we consider Mutual of Omaha and its people as good citizens. We think they are running a good insurance company. We do know that they participate in those things that mean something and particularly in the civic consciousness of the community and the State.

And I think that perhaps, by and large, we can say that on a national basis, and particularly when we see that Animal Kingdom and other TV productions which are watched very, very widely. I recall one answer given by a high official in Mutual of Omaha, when an observation "Keep them coming," was made as to the quality of those TV programs, and the official replied, "Keep on buying more insurance and we'll keep the programs coming."

Now, I say that because it is a competitive business—as nobody knows better than these people from this organization but in a serious vein, I want to say that I'm confident that what these witnesses will tell by way of testimony will not only be fact but will be relevant fact, and I'm looking forward very much to the presentation.

Senator HART. Thank you.

With that warm welcome, Mr. Skutt.

With no objection, the prepared statement, with exhibits, will be printed in the record in full as though given in full, and as you pro-

ceed, if there is any footnoting or skipping, you may be assured that the record itself will reflect in full the prepared testimony.

Mr. SKUTT. All right.

(The prepared statement follows. Testimony resumes on p. 1208.)

STATEMENT OF V. J. SKUTT, MUTUAL OF OMAHA BEFORE SENATE ANTITRUST AND MONOPOLY SUBCOMMITTEE, JUNE 8, 1972

I am happy to participate in this important hearing and to provide your Committee with information in response to your communication dated March 15, 1972.

It is apparent from all that has gone before in your hearings, and in the vast studies which have been made, that provision of adequate health care for all Americans—regardless of their financial condition—can only become a reality by a pluralistic approach. This encompasses utilization of all private instrumentalities and their personnel. To this end you have my assurance of the complete cooperation of our organization and its people. It is obvious that further governmental involvement in financing health care could impose impossible additional fiscal burdens on our already debt-ridden government—and still fail to improve the situation, unless there is widespread participation on a proper basis by all who are qualified to assist.

BACKGROUND

First, then, I would like to point out some of the progress that has been made in the health insurance field generally, and by the organization with which I am associated, in working toward these related objectives during the past many years.

The empirical development of health and accident insurance in America is the product of a need on the part of the public and the work and experimentation on the part of insurers.

In the United States today, substantial health care is financed through a broad network of private health insurance.

However, the history of such insurance is one of halting early developments, experiments, then rapidly accelerating development and growth, particularly since the mid-1930s.

In response to the public need for some financial coverage against the frequent rail and steamboat accidents of the mid-nineteenth century, the nation's earliest accident insurance company came into being in 1850. By the turn of the century, 47 American companies were issuing a varied line of accident insurance coverages.

The acceptance of accident insurance paved the way for sickness and disability income insurance. The first individual policies offering disability insurance began to appear in 1890.

The first decade of the new century saw the introduction of additional benefits in some individual disability income policies for hospital confinement.

And it was toward the end of this decade—March 5, 1909,—that the Articles of Incorporation for the "Mutual Benefit Health & Accident Association" (later to become known as Mutual of Omaha) were filed with the Nebraska Insurance Department.

The record shows that many insurance companies organized during the early 1900s failed because of inadequate reserve bases and lack of experienced leadership. Such was nearly the fate of Mutual of Omaha. The incorporators of the Company faced such problems that half of them resigned during the first year.

But C. C. Criss, a student at Creighton University at Omaha, who was selling insurance while working his way through the Medical College, was persuaded to take over the management of the faltering firm in 1910. Young Dr. Criss saw the need for more liberal coverages than the very limited policies of his day. He established the cornerstone of Mutual's tradition of providing health insurance designed to relate to need and cost.

The first basic policy sold by Mutual paid \$20 a week for a disability caused by an on-the-job accident. To liberalize this policy, provisions were added to cover accidents both on and off the job. Next, coverage for sickness was offered.

Mutual of Omaha improved the coverage of its policies during its second decade of operation. The Company showed leadership toward the goal of simplification and liberalization of provisions. It helped initiate such specific improvements as

a broad insuring clause and the elimination of occupational prorating features. The young organization liberalized its underwriting rules to provide disability coverages for the average working man as well as the professional or preferred risk to which such coverages had previously been limited.

The many financial and operating problems facing this institution and other companies at that time were met through the courageous efforts and far-sighted vision of the insurance people of that earlier day. *Without their interest and efforts in this field no plans of financing health care would have been available to the people of that time. Nor would we today—in government and business—have the statistical data and other essential empirical information for proper planning in this field.*

The difficulties of actuarially forecasting the future of health insurance in a rapidly evolving economy, including several major wars, great mechanization, shift from rural to urban living, and the development of a service economy, seem even more formidable in retrospect, even though the medical care revolution and the spectre of inflation were not yet fully anticipated.

Experimentation in coverages and stepped-up services continued to be rendered from the 1920s through the early 1930s when the depression adversely affected further progress. Figures show that loss ratios rose sharply and premium income decreased with equal volatility. This was a bad combination. But Mutual of Omaha, through the combined efforts of its Agency force and Home Office personnel, weathered the storm without any government subsidy or financial assistance of any kind.

Enlightened by these difficult experiences, and strengthened by the unity of its people produced through trials and adversity, Mutual of Omaha was in good position to move forward in the 1940s. It began to provide further expanded coverages to meet the proven needs of the public. In the latter part of this decade when the health of Dr. C. C. Criss failed, the Mutual of Omaha Board was enlarged and early in 1949 my appointment to succeed Dr. Criss as Chief Executive Officer was authorized.

EARLY DEVELOPMENTS TO AID THE CONSUMER

One of the first actions we took was the creation of a program to recognize research and to encourage outstanding contributions to the health and safety of the people. This was developed into the Mutual of Omaha Criss Award which is unique in its field. It has attained high stature as an instrument of recognition for extraordinary contributions in the field of health and safety.

We also determined at this time to develop a broad family plan which combined hospitalization and loss of time and other benefits. This made it possible for the insured and the members of his or her family to be included in one comprehensive program.

In this connection, Mutual of Omaha pioneered the renewal safeguard provision which provided that the Company could not terminate the policy because of changes in health.

Recognizing the need for the utmost clarity in order that the policyowner understand the coverages, positive steps were taken accordingly to avoid misinterpretations.

Some of the many actions taken to assist the policyowner in understanding his coverage were:

- (1) The format of the policy was changed so that any exceptions were prominently printed in the very beginning of the policy and before any description of benefits.

- (2) A special clause was prominently published on the first page of regular policies which allowed the insured to return his policy and receive a full refund of premium if not satisfied with the policy for any reason.

- (3) In this same clause of the policy the insured was also reminded to examine the copy of his application which was attached to the policy. (See Exhibit A in reference to points 1 through 3.)

- (4) At considerable expense a special letter is written to each new policyowner within two weeks after his policy is issued. It encloses a copy of the application and asks the policyowner again to verify the information, he is asked to respond confirming the information to avoid any misunderstanding. An excerpt from the letter follows:

"... Your policy has been issued relying upon the information contained in your application. A photocopy is attached and is made a part of the policy.

"It is very important to you—and to us—that your application contains complete and accurate information. Enclosed is a photocopy of your application and we ask that you review it carefully and if incomplete in any respect provide us with any additional information. Factual and well-defined answers to all of the questions now will prevent misunderstandings at a later date.

"Please complete and sign the appropriate spaces provided below, and return to us in the enclosed envelope. It is not necessary to return the photo. We sincerely appreciate the confidence you have expressed in our company and the courtesies you extended to our representative . . ."

ADDITIONAL CONSUMER AIDS

Many internal steps were taken contemporaneously with these programs, such as a complete new educational and training plan for sales representatives. This was put together under the aegis of an outstanding authority and educator, the late Bert Jaqua, Dean of the Colleges of Insurance of Purdue and Southern Methodist Universities. It included an indoctrination program designed to assist the field underwriter or salesman with the highest degree of knowledge and responsibility in his relations with prospects and policyowners.

Why this emphasis on education of agents? Because, in our opinion, insurance is most susceptible to misunderstanding when the layman's exposure to it is exclusively through written communications and articles or ill-advised personal presentations. Recognizing that misunderstandings in insurance are due to this absence of proper communication to the insured or prospect at the time the policy is issued, or organization in the early 1950's initiated this in-depth educational and training program for field underwriters or salesmen to qualify them to answer the questions and meet the need of the prospect and policyowner, and eliminate future disappointments because of lack of understanding of the coverages.

Again, in the interest of the consumer; i.e., the policyowner, and to assure prompt and proper service for him, steps were taken in the Claims Department to establish regional directors throughout the country with closer liaison with hospitals, physicians, etc. In order to provide a grass roots evaluation of services to policyowners, costs, etc., these regional directors were instructed to make regular visits to hospitals and report the results thereof.

POLICYOWNER SATISFACTION

Then, to ascertain the reaction of its policyowners with respect to all these steps that had been taken and to seek direct information on the services rendered, a nationwide policyowners' survey was made. The policyowners responded with a remarkably high percentage of endorsement of our extra efforts.

So far as we know it is one of the first times any institution conducted a survey of this kind. An excerpt from the report of the survey, conducted by an independent nationally-known accounting firm, follows:

"In your recent policyowners' survey, we independently controlled the mailing of questionnaires and the receipt and tabulation of replies.

"509,951 questionnaires were mailed. The survey represented a good cross section of policies in force, geographical location of policyowners, and modes of payment.

"The questionnaire included the following question: 'Have you been satisfied with Mutual's overall services?'"

"Ninety-seven percent of the policyowners replying directly to us in response to the above question indicated satisfaction . . ."

It will be noted from the above that 97% of those who responded indicated satisfaction. If it is to be assumed that those who did not respond were also satisfied, then the percentage of satisfaction of policyowners would even be higher.

GROWTH AND EXPANSION

In early 1950, a Special Risk Division was created to meet the need for a variety of types of new coverages, including air trip and other travel insurance, student insurance coverages, etc.—all to meet the changing needs and lifestyle of the American public.

The need for extension of commercial rates to users of the Military Air Transport Service was recognized and provided in 1956. This was one of many

ways in which Mutual of Omaha has worked jointly with Federal Government in meeting many special insurance needs.

It is perhaps best illustrated after the enactment of Public Law 569 of 1956. (This is now known as the CHAMPUS Program—Civilian Health and Medical Program of the Uniformed Services.) Under the provisions of the law and regulations, invitations were extended to health insurance organizations to administer this program on a "cost only" basis.

Mutual of Omaha was the only commercial health and accident insurance company to respond affirmatively. It was assigned 17 states. Our record for the first years is attached as Exhibit B. It should be pointed out that this comparison is based on the overall experience of the only other administrator of the program in all of the other states. The program demonstrates that the public and the government both benefit where various intermediaries and administrators in the private sector do not have a monopoly on the services to be rendered. This is a vital ingredient to any program of health care; namely, that more than one instrumentality provide the service so that there can be comparisons and motivation for superior performance and lower cost. This cannot possibly exist under a monolithic program of financing the functions involved in the delivery of health care.

During all of this period, Mutual of Omaha was extending plans of coverage to other segments of the civilian population, including people of all ages. Its coverages for those 65 years of age and over, regardless of health, were initiated on a nationwide basis in 1959. Unlike most other plans, this program provided coverage for confinement in nursing homes, as well as hospital and surgical benefits.

With the advent of the new Medicare Program in 1966, Mutual of Omaha—while continuing to provide supplementary coverages—offered its services as an intermediary to help the government in the administration of this involved, expensive and far-reaching program. Mutual of Omaha was prepared to serve as intermediary for the same 17 states in which it had rendered such outstanding service at such low cost in the original Medicare (CHAMPUS) Program, as previously discussed and reported in Exhibit B.

By action of the Department of Health, Education and Welfare, Mutual of Omaha was initially appointed intermediary for Part B of the Medicare Program for only the Virgin Islands and its domiciliary State of Nebraska. Mutual of Omaha indicated its continued willingness to cooperate and assist in the Medicare Program and later was assigned a large number of nursing homes, some additional health agencies and hospitals under Part A of Medicare. Again, as in all other services for the government and the public, Mutual has endeavored to conscientiously and economically carry out good health care financing objectives. Under the complex Medicare Program it has encountered the usual difficulties of satisfying the public and at the same time paying only those benefits covered by the law.

The same dedication to service to its policyowners that Mutual of Omaha has manifested in its service on government associated projects has marked its efforts in providing coverages for all segments of the American public with "maximum benefits at minimum cost." This is largely responsible for the fact that this Nebraska based institution occupies its position of leadership in the field. And we assure you that Mutual of Omaha and its affiliates are primarily and vitally interested in service, in consumerism, and in meeting its social responsibilities through a sound and efficient administration of its many programs of economic security designed to help people in all walks of life.

SUFFICIENT RETURN

In your letter of March 15, the first question is: "Whether or not commercial accident and health insurance companies are returning a sufficient amount of the individual or group accident and health insurance dollar in benefits to consumers?"

This, like most generalized queries, calls purely for an opinion. What is a "sufficient amount"? Mutual of Omaha paid benefits to more than one and a quarter million persons (exclusive of CHAMPUS and Medicare payments) in 1971 alone. The amount was important in all cases. We hope it was "sufficient" in most cases to meet their needs. Many policyowners receive thousands of times the amount of premiums paid when serious disabilities are sustained. In December we passed \$4 billion in cumulative benefits paid to policyowners. (See Exhibit C.)

But to endeavor to relate the exact return per dollar to the consumer, i.e., the policyowner, for any given fixed period of time could not accurately reflect the value of the protection received for the premium paid. To the individual who does sustain a loss, this benefit could be the difference between solvency and financial disaster and despair. To those who did not sustain a loss, the knowledge that the protection existed could well have contributed to their peace of mind and well-being.

Therefore, while in the insurance field the ratio of benefits paid to policyowners varies by company and policy form, on the whole it would appear that the public is receiving a good return for its premiums. It must be remembered in this connection that the purpose of such coverage is protection and not investment. Unlike life insurance or some other forms of coverages, individual and family as well as group accident and health insurance is provided strictly to help meet the costs of sickness and injury. It is not marketed—or at least should not be, in our opinion—as an investment in the usual sense.

Health insurance policies are probably the most complex to administer. Proper premium and benefit provisions are not easily determined. Statistics are available to this Committee that indicate underwriting results for portions of the accident and health industry have occasionally reflected tremendous financial losses. We note in this connection that government Medicare rates themselves have undergone periodic revisions—always upward and with some confusion.

If the question of "sufficient return" by individual health and accident institutions is concerned with the amount paid related to the amount collected, then we must consider the costs of research and development, acquisition, proper claim handling, general administration, etc. So to determine the adequacy of return, it would be appropriate to take a look at the spread of the costs of some other necessities. Certainly there is an obligation on the part of all business institutions, including insurance, to see that all consumers receive more benefits for the prices paid, just as there is an obligation on the part of the government to see that taxpayers receive more benefits for taxes paid.

One might ask what is a "sufficient amount" of any service or product returned to the consumer for the price he pays? Many consumer retail products have a far lower "return ratio" than insurance. Many essential pharmaceuticals, medicines, etc., are produced for less than 50% of their retail cost. Though nutrition is vital to "health care," cereals frequently cost the manufacturer less than 40% of retail price, and many foodstuffs have much higher distribution costs than insurance. We are told automobiles can be produced for approximately 50% of retail price. In each of these examples the consumer is paying for distribution costs, research and development, reserves for future contingencies, etc.

Are the consumers in the field of tangibles getting a "sufficient return" for their dollar when the actual product costs less than 60% of the retail price? Or in the field of intangibles such as title insurance or bail bond insurance—where the buyer seldom gets any direct financial return for his premium, has he not received "sufficient" return in the way of much needed protection? As has been said before, the purpose of many forms of coverage is protection and not investment.

Thus, when compared with other necessities, the difference between the actual cost of the product and the distribution, handling and administrative expense in personal health insurance compares favorably. It also must be remembered that most of those other products are merchandised through stores or facilities and do not require extensive, personal sales efforts and contacts. On the other hand, in the field of individual health insurance, the policy (or "product") must be sold on a person-to-person basis. The agent representative is ordinarily required to make several contacts in order to consummate a single sale. And the servicing of the policyowner after purchase, including the payment of benefits, must be handled on individual basis.

OTHER SERVICES RELEVANT TO SUFFICIENT RETURN

But health insurance institutions render other services material to determining whether or not the return for the premium paid is "sufficient." Many of these services are difficult to evaluate precisely, but they are very valuable to the policyowner and to the public generally.

In the case of Mutual of Omaha, a Rehabilitation Division was established in the late 1950s. It provided for a comprehensive rehabilitation program and included separate provisions in the policies to that end.

This program was developed with the advice and assistance of the late General Melvin Maas, USMCR, Mutual of Omaha Board member who served as Chariman of the President's Committee on the Physically Handicapped by appointment of both Presidents Dwight D. Eisenhower and John F. Kennedy. He conducted a real indoctrination of our people regarding the importance of rehabilitation, which began an inspirational chapter in the life of our organization.

Under this program, the insureds received the policy-provided monthly benefits for total loss of time while participating in an approved, vocational or on-the-job program of rehabilitation. This progressed to the present plan of assisting disabled policyowners by paying benefits for expenses incurred for the evaluation, vocational assistance and medical management necessary to determine re-employment. For its service in this field Mutual of Omaha has received several national and state awards. The effects of these programs on some of these policyowners are exemplified in the attached *Exhibit D*.

We have learned through this program that a request for health care is often as much attributable to the nature and character of the individual as it is to the diagnosis of a disease. Some persons with relatively minor conditions—in the absence of encouragement or motivation—seemingly seek frequent health care. There are many examples of others with serious conditions who, because of their particular make up—and with encouragement and motivation—have overcome the need for health care, and in fact have become productive citizens again. It has been pointed out by authorities that unnecessary hospitalization, medication, etc., have added greatly to the cost of health care.

Yet rehabilitation has been seldom referred to in the vast material compiled on the system of delivery of health care. *Thus, we believe that there should be more emphasis on the reorientation of efforts in this area than has been demonstrated in the past discussions on the delivery, quality and cost of health care.*

We at Mutual of Omaha now regard rehabilitation as an integral part of our obligations to the policyowners and public. It does indeed contribute to the "sufficiency" of the return to holders of individual policies.

Some other examples of our efforts to utilize premiums in the best possible manner to promote advancement in health care are:

(1) Mutual has a program (the Mutual of Omaha Criss Award, previously referred to) for recognizing significant contributions in the areas of health and/or safety. This Gold Medal and five-figure financial grant have been given to such individuals as Doctors Phillip Hench and E. C. Kendall for their work in the research and development of cortisone (1950); to Dr. Howard Rusk for his great work in the field of rehabilitation (1953); to Dr. Jonas Salk for his work with the vaccine which bears his name (1955); to Dr. Tom Dooley for his efforts with the medically indigent (1959); to former actor William Gargan for his outstanding work in behalf of the American Cancer Society to help rehabilitate cancer patients (1965). See *Exhibit E*.

(2) Personnel of the organization have worked full-time with Community Health Planning agencies whose main task it is to help produce better health care while still reducing the costs of same. Several officers and field personnel, as well, have been involved with this program, which is an essential link in the future planning for health facilities, etc.

(3) The organization has provided substantial financial aid to programs such as the United Community Services and has been a leading contributor of personnel to work and lead such campaigns.

(4) The organization has donated substantial sums to hospitals and provided members of their boards, chairmen for their fund drives, voluntary help, etc. Many such projects relate directly to free medical aid for the indigent.

(5) The organization has received much credit for the financial and personnel aid which was largely responsible for the Creighton University Medical School remaining open when it appeared this institution would be closed. (See *Exhibit F*.) The school maintains a clinic for the indigent. A relationship has been established to cooperate on a program of education to speed up availability of doctors and paramedics, etc.

(6) The organization established a unique program for the Canal Zone Administration which provided a previously untried method of taking medical care directly to native workers in jungle circumstance. Much public comment has credited the organization with helping avert a serious internal crisis in the country caused by lack of care for these native workers.

(7) The organization has made substantial contributions to medical research and educational funds, as well as scholarship aid, matching of employees' contributions, etc.

(8) The organization sponsored the first pilot cancer project in the country which provided indigent women with free kits to self-administer "Pap" tests.

(9) The organization has given regularly to all of the major private fund drives for research conducted by organizations such as the Arthritis Foundation, Cancer Society, Heart Fund, etc. Many personnel have been active at all levels of voluntary leadership, including national and state chairmanships.

(10) Mutual of Omaha has oriented much of its advertising to the problems of educational and environmental programs, tying in with wholesome entertainment features to keep audience attention. It has endeavored to encourage people of all ages to help provide for their security through its coverages and at the same time to recognize and participate in programs for the conservation of human and natural resources.

(11) The organization has been extremely active in the area of experimental research on new methods of health care delivery, such as through Health Maintenance Organizations, Surgi-Centers, outpatient clinics, etc.

GROUP INSURANCE

As the Committee is aware, there is considerable variance in the percentage of premium directly returned in group insurance, as distinguished from individual or family insurance. This is due in large part to the method of distribution and administration. It is common knowledge that in group merchandising of any product, there is a lower cost factor than where sales, clerical records, administrative handling, etc., are all done individually.

It would appear from the high losses sustained in the overall group health coverages that there is little question but what a "sufficient" amount of the premium is directly returned to the consumer. The return of our organization is certainly comparable to other major group writers and shows that this type of business is marginal with regard to operating profit. Nonetheless, as indicated in our response to your initial questionnaire regarding group insurance, procedures are established and implemented to help control the cost and quality of health care services received by those insured under our group policies.

These procedures encompass the verifying that hospitals satisfy policy requirements regarding license and have appropriate rules of admission, the screening of short-term patients for whom outpatient treatment or diagnosis might have sufficed, the screening of confinements regarding duration of confinement, the verifying of the necessity of professional services rendered and the determination that all charges are reasonable and customary for the geographic area involved.

INDIVIDUAL CHOICE VS. STANDARDIZATION

The next inquiry in your March 15 letter asks "whether or not accident and health insurance policies should be standardized by regulation."

To a degree, individual accident and health insurance policies are now subject to standardization as a result of the Uniform Policy Provisions Law, which has been enacted in all states. This law specifies a number of required and optional provisions for all policies, as this Committee is aware. Fortunately, the designers of this law had learned from the mistakes of earlier years. Allowances were included to permit the individual insurers to use policy language more liberal than the statutory language in the subject areas; thus, requirements were established for benefit of the policyowners in such a way that improvements and liberalizations by insurers were not foreclosed.

We do not see any need for further standardization. Proponents of this concept oftentimes contend that it would contribute to policyowner understanding. We believe this contention fails to recognize that regulatory authorities are empowered to disapprove policies which are unjust or misleading, or encourage misrepresentation, or contain benefits which are unreasonable in relation to the premiums charged.

Further standardization is not only unnecessary, but would be adverse to the best interests of the public. Flexibility must be maintained in order that insurers continue to be able—

- (1) to tailor each individual's coverage to his personal needs or desires,
- (2) to vary the coverages and the amounts by geographic area, and
- (3) to adapt rapidly to changes in health care patterns.

No one would accept a conclusion that medical science has attained its ultimate development, but this is what seems to be implied in suggestions to standardize health insurance policies.

The public interest would be adversely affected, too, in that standardization would deter or possibly eliminate the element of competition to develop and market the best health insurance coverages. Standardization, in fact, would appear to be contrary to the very purpose of the Subcommittee on Antitrust and Monopoly. Competition in product development has been the prime mover in improvements of coverages through the years and must be maintained.

COMPETITIVE RATES VS. REGULATED RATES

Competition is a key element also in the consideration of the next question in your letter—"whether or not accident and health rates should be regulated."

This matter has been a subject of study and review by the National Association of Insurance Commissioners from time to time for many years. This body has recognized that rate regulation, as such, is neither necessary nor desirable. The states have the power to disapprove policies which contain benefits unreasonable in relation to the premiums charged, as previously mentioned. This power is adequate for the policing of rates, and it can be used in a manner to preserve the circumstances under which companies can innovate, expand and otherwise improve coverages.

Rigid rate regulations of the multi-faceted health insurance coverages would be a straight-jacket from which improvements could emerge at best at a painfully slow pace.

As a regulator, competition has proven to be effective and timely as well as economical. We earnestly recommend support for the existing long-standing state machinery for supervision of rates, with its ability to protect the public and its capacity to accelerate improvements in the public interest.

STRUCTURAL AND FISCAL CHANGES FOR THE FUTURE

The final matter on which you requested my views has to do with any overall structure and fiscal changes which might be necessary to effectuate a system of comprehensive health care and insurance, including preventive and outpatient health care services, for all persons regardless of their financial means. Such a system, of course, is the objective toward which all health care segments of our society—providers, insurers and federal and local governments alike—have labored for so many decades. Although these efforts have indeed produced remarkable advancements, it is clear that dedicated endeavor on the part of all must continue.

It seems equally clear that the most ideal of systems can only be an effective blueprint during the immediate future. Until such time as the nation has sufficient manpower and facilities and adequate distribution of these resources to render the services needed, the ideal will remain a blueprint. Thus, the first priority must be alleviate, and eventually eliminate, the shortages and distribution problems which now exist. An indication of our interest and efforts in this area is reflected in the attached Exhibit F.

EDUCATION—PERSONNEL—FACILITIES

Our educational institutions have the expertise to furnish an increasing supply of physicians, nurses and the allied personnel to release the more highly trained professional people from the many relatively menial services they are called upon to provide. Our younger generation includes an abundant supply of persons capable of mastering these disciplines. We have been told of one medical school which had over 100 applicants for each student it could accommodate in its incoming first-year class.

Many of our medical schools are in need of financial assistance to pursue their goals and expand to educate more students. It seems advisable to implement improved grant and/or loan programs for many of the students as well.

Relief of quantitative shortages, unfortunately, will not assure accessibility to health care for all of our citizens. The shortage will remain very real for those geographically removed from what might be considered, in the aggregate, an

abundant supply of professional services. Inducements must be furnished to the professional people and their associates to serve in geographic areas to which they might not otherwise be attracted. It seems that a program of grants would be most effective here, too. Such a program could include, in consideration of services rendered in areas of geographic shortages, the partial satisfaction of the loans previously suggested for purposes of acquiring the requisite education.

It is necessary, too, to create a situation in which institutional health care providers are as geographically accessible as possible to all. While it appears that grants and subsidies would again be required for this purpose, we have here an opportunity to promote the development of facilities which should prove to make more efficient use of the health care dollars. Certainly, such institutions can and should be directed toward the concept of health maintenance—including preventive care—and geared to furnish ambulatory (outpatient) care whenever such care is appropriate for the patient's management. Our investigation of and assistance in the formation of such instruments for delivery of quality health care at predictable cost is exemplified by the following excerpt from a report by one of our Associate Medical Directors:

"Mutual of Omaha—again as a matter of sound business practice—has consistently sought methods of health care delivery which assure quality at predictable cost. This has involved investigation of innovative methods of health care delivery and the encouragement of those exhibiting these desirable characteristics.

"The pursuit of this principle has led to our investigation of many modalities. Among these has been the concept of ambulatory surgical care which is most impressive in its capacity to deliver high quality surgical care at predictable and much reduced cost. We encourage and foster this concept of outpatient surgery.

"While long interested in group practice as a convenient and quality method of providing health care, the formalized and government sponsored Health Maintenance Organization has provided a welcome impetus to the concept of group practice with dual choice, i.e., fee for service or prepaid capitation. Such a choice is consistent with a pluralistic system which provides options yet has the potential for convenient consultation, peer review, and effective resource management. Such potentials are bound to result in cost savings to the benefit of both provider and patient.

"Because the HMO concept possesses the potentials noted above, Mutual of Omaha is currently involved in negotiations encouraging and assisting the formation of these instruments for health care delivery. We are prepared to provide essential services in the areas of our expertise—i.e., market surveys, marketing, actuarial services, administrative management and underwriting, indemnity, reinsurance and contract service.

"Currently our Company is assisting the Criss Institute for Health in establishing the first HMO in the Omaha area—indeed the first in all of Nebraska. It is our belief that such an organization backed by the Criss Institute for Health will provide a needed and desirable modality for the delivery of quality health care in our area. It should be noted, however, that this local activity is only one expression of our interest in the HMO concept. We are dealing with other such organizations in various states of formation nationwide."

SOME PROGRESS

There is need for one additional comment in the discussion of quantitative shortages and improper geographic distribution of trained medical personnel. It was very satisfying to note that press notices in the latter half of May announced the Department of Health, Education and Welfare was sending over 150 physicians and several hundred other trained medical personnel to "medically deprived" areas. It is understood this was made possible by the 1970 Emergency Health Personnel Act. This is very obviously a step in the right direction. It may well be that an instrumentality already exists to partially solve some of these problems.

COST AND QUALITY CONTROL

Inherent in uncoordinated programs to develop additional manpower and facilities are the dangers of over-development or over-concentration, with the resultant unnecessary duplication of costly edifices and equipment and the tendency toward the rendering of unnecessary services. These undesirable and very costly situations must be reduced to a minimum by the continuing estab-

lishment of local and regional comprehensive health planning agencies, especially if such agencies are given the authority and financial support to assign and effectuate priorities in the expenditure for and sharing of resources.

While strong comprehensive health planning agencies contribute significantly to the control of the cost and quality of health care, it is quite possible we have already witnessed the emergence of equally or perhaps more meaningful control mechanisms; namely, the professional Peer Review Committees and the institutional Utilization Review Committees. Our experience with such committees has indicated that their purposes are sincere and effective, and we are confident that their voluntary proliferation will continue to the advantage of all patients and policyowners.

Following is a description of the activities of our registered nurse analysts and associate medical directors in the claims review process in our Health Insurance Benefits Division. Expansion of this process is presently planned.

"Claims for professional services and for institutional care as well as drug costs and services ancillary to institutional care are routinely reviewed using customary and prevailing cost guidelines for such services and care. In this connection 'customary' is that level of claim characteristic or customary for the individual or institutional provider of health care and 'prevailing' is the same applied to an area of the country. This latter consideration recognizes the fact that there are high-cost areas—not only for health care but for all things and services in these areas.

"Customary and prevailing claims are paid as fair and equitable. When, however, it appears that claims are excessive, they are subjected to close scrutiny through successive levels of increasingly sophisticated review. In the course of these reviews not only are the claims considered from the 'customary and prevailing' aspect but also for the appropriateness of level of care. It is in the course of these reviews that our nurse analysts and/or our associate medical directors contact the providers of care to ascertain the reasons for claims exceeding the 'customary and prevailing' guidelines. Contacts are made either by telephone, letter or both. We have found telephone liaison more effective and satisfactory in that prompt resolution of differences if possible reduces the incidence of retroactive denials. Individual physicians, nursing supervisors, administrators, pharmacists, and both peer and utilization review committees are contacted as indicated. Often additional information and records are requested to assist in claim evaluation.

"If, after thorough review, a claim cannot be substantiated or a higher than needed level of care justified, payment is refused or an amount of compensation offered consonant with customary and prevailing charges. If, in the case of a physician, the provider refuses to accept the reduced claim, he can appeal to the local peer review mechanism to judge the propriety of the charge. Very few physicians make this appeal, largely, we believe, because of the careful and impartial reviews to which excessive claims have been subjected by our professional staff. In the case of an institution, the Utilization Review Committee of the local medical society judges the level of care appropriate to the case. From a slow and uncertain start URCs have steadily improved. We strongly support a studied effort to have members of our professional staff meet with these committees as a part of an education and information exchange program designed to bring better understanding of the public laws and the necessity for cost control in the delivery of quality health care.

"It is obvious that the key factor in cost control is the prevention of overcharging and overutilization of services and facilities—physicians', ancillary medical, and institutions'. These latter provide different and cost varying levels of care appropriate to individual case needs. Insurance companies can act as one entity in a milieu of factors to effect cost control. Mutual of Omaha as a matter of sound business practice conscientiously reviews claims submitted to it. These reviews do encourage and effect cost control not only directly but also indirectly through the process of education."

In addition to our individual effort, we also contribute substantially to the many insurance associations whose goals include the provision of maximum insurance coverage for necessary medical care while helping to control the cost and improve the quality and efficiency of the delivery of health care services.

The topic of cost control reminds us of our belief that a most important endeavor seems to have escaped, in our national dialogues, the emphasis it deserves; that is, the endeavor to rehabilitate the seriously disabled. We again recommend as a matter of utmost importance a meaningful program of rehabilitation to stimulate and motivate people to do things for themselves, thereby over-

coming their disabilities where possible and continuing to contribute to the productivity and strength of our country. An important ancillary benefit, if such rehabilitation can be accomplished in the numbers we think possible, would be a savings in health care cost resulting from a reduction in the use of drugs and medicines, unnecessarily long hospitalization and excessive demands on other health care services and facilities.

FISCAL CONSIDERATIONS

There remains, even if we devise and implement an efficient delivery system to make all preventive, therapeutic and rehabilitative health care services accessible to everyone, the question of financing these services. The phraseology in your communication of March 15 appears to recognize that the problem of financing health care costs is different for those who do not have sufficient financial means than it is for those who do. We are in complete agreement with this premise. We find no justification for requiring the less affluent, through tax payments or any other device, to subsidize health care for those who have the means to provide it for themselves individually or through participation in programs paid for by their employers.

On the other hand, individuals and employers with sufficient means must oftentimes be induced to expend resources for protection against unexpected health care costs. Tax incentives are motivating for many other worthwhile purposes and could be expected to stimulate employers and the self-sufficient to acquire such protection from the private sector. This approach would capitalize on the establish expertise and mechanisms of the existing health insurance industry, thus minimizing demands on the resources of governmental units.

In consideration of this suggestion regarding tax incentives, there will be those who again question the percent of premiums returned by the private insurance sector in direct claim payments to policyowners. The question has been fully addressed previously in this statement. It may be added, however, that no personal financing system—even if it produces a 110% return of the premium dollar to the consumer—will provide more doctors, nurses, hospitals or research than are now available.

Exhibits accompanying statement of V. J. Skuitt, Mutual of Omaha

*Referenced
on text page*

- | | |
|--|----|
| A. Example of Policy First Page..... | 5 |
| Illustrates prominent display of policy exceptions, prior to listing of benefits. | |
| Illustrates reminder to review application. | |
| Illustrates guarantee of satisfaction—to verify that policy provides coverage as represented by the agent and understood by the consumer. | |
| B. Comparison of Claims Administration Costs for the CHAMPUS Program (Civilian Health and Medical Program of the Uniformed Services)---- | 7 |
| Compares efficiency of Mutual of Omaha with other intermediary in the administration of a government sponsored plan. | |
| C. Mutual Records Payment of \$4 Billion in Total Benefits..... | 9 |
| 1971 Annual Report describes latest benefit milestone. | |
| D. Rehabilitation Booklet, "Helping Others . . . "----- | 12 |
| Case histories of a few of the many policyowners helped by Mutual of Omaha's Rehabilitation Policy Provision. | |
| E. Mutual of Omaha Efforts to Recognize Individual Contributions to Health and Safety----- | 13 |
| Press reports on several Mutual of Omaha Criss Award recipients. | |
| F. Mutual of Omaha Support of Health Care Education----- | 14 |
| Commendation letter from Creighton University. Press reports on Mutual's contribution in the areas of Health Care Education and Health Maintenance Organization plans. | |

EXHIBIT A—MUTUAL OF OMAHA

(Reference page 5 of text.)

Example of policy first page. Illustrates the prominent display of exceptions, the reminder to review the application, and the guarantee of satisfaction.

Mutual of Omaha Insurance Company—Dodge at 33rd Street, Omaha, Nebraska 68131, (Herein called the Company) Hereby insures the Insured and promises to pay the benefits herein specified, subject to the provisions and limitations of this policy. This policy is issued in consideration of the statements in the attached copy of the application and the payment of the Initial Premium in advance.

TEN-DAY RIGHT TO EXAMINE POLICY

Please read this policy and the attached copy of the application carefully. In the event the Insured is not satisfied with the policy for any reason, it may be returned within ten days after receipt and any premium paid will be refunded.

EXCEPTIONS AND LIMITATIONS

Benefits are payable for mental diseases or disorders but not to exceed six months during any one period of confinement.

Benefits are payable for childbirth, pregnancy or complications resulting therefrom but only as provided in Part E.

Benefits are not payable for: (a) confinement beginning while this policy is not in force, (b) injuries or sickness for which any benefits are provided for by workmen's compensation or employer's liability laws, (c) injuries or sickness resulting from an act of declared or undeclared war or sustained while a member of an armed service (upon notice to the Company of entry into such service, the pro rata premium will be refunded) or (d) services provided by or paid for by the Veterans' Administration of the United States Government.

EXHIBIT B—MUTUAL OF OMAHA

(Reference page 7 of text.)

Comparison of claim administration cost. Shows relative efficiency of Mutual of Omaha and other intermediary in administering the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

A COMPARISON OF OPERATIONAL ADMINISTRATIVE COST FOR EACH CLAIM (HOSPITAL)

The following is public information and is taken from the Office for Dependents' Medical Care Annual Reports to the Congress:

	Audited cost for each claim		Difference
	Blue Cross	Mutual	
Dec. 7, 1956, to June 30, 1957	\$2.86	\$1.44	\$1.42
July 1, 1957, to June 30, 1958	1.88	1.26	.62
July 1, 1958, to June 30, 1959	1.74	1.35	.39
July 1, 1959, to June 30, 1960	2.20	1.66	.54
July 1, 1960, to June 30, 1961	2.14	1.48	.66
July 1, 1961, to June 30, 1962	2.25	1.15	1.09
July 1, 1962, to June 30, 1963	2.31	1.26	1.05
July 1, 1963, to June 30, 1964	2.34	1.34	1.00

Source: Based on official U.S. Government records.

PAGE 2 OF EXHIBIT B—MUTUAL OF OMAHA

Cost comparison continued.

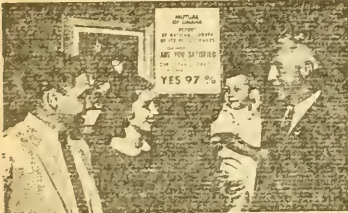
A COMPARISON OF ADMINISTRATIVE COSTS

During the period from Dec. 7, 1956, through June 30, 1964, the average administrative cost for each claim by Blue Cross was \$2.15 while Mutual's was \$1.35.

	Number of claims	Administrative cost	Administrative cost for each claim
Blue Cross	1,368,044	\$2,936,216.42	\$2.15
Mutual	694,498	936,469.50	1.35
Total .....			.80

Note: \$0.80 equals 38 percent lower administrative costs. Based on the total number (694,498) of hospital claims handled by Mutual, this amounts to a savings of \$557,970.79. During this same 7½ years, Mutual also processed an additional 296,372 claims from physicians in the States of Texas, Ohio, South Carolina, Alabama, and Rhode Island which, when added to the 694,498 hospital claims, amounts to a total of 990,870 hospital and physicians' claims processed for a total savings to the Government of \$794,005.95. It is significant to note that the physicians' claims amount to approximately 30 percent of the total volume. Since actual records show that handling physicians' claims is more costly than hospital claims, it can be concluded that Mutual's average administrative cost for each claim of \$1.35 would have been considerably lower. (Our average cost a claim of \$1.35 has been figured on the basis of administrative costs for both hospital and physicians' claims.)

first billion



1958 Michigan farmer Earl McMunn was 22 when he and his family received the "one billionth dollar" check from Chairman V. J. Skutt. The McMunn's have collected benefits 12 other times since then.

second billion



1964 Machinist Bryant Brown, our "two billion dollar" policyowner, is still receiving benefits at his home near Hartford, Connecticut. Mutual has paid the Browns over \$42,000.00 to date.

third billion

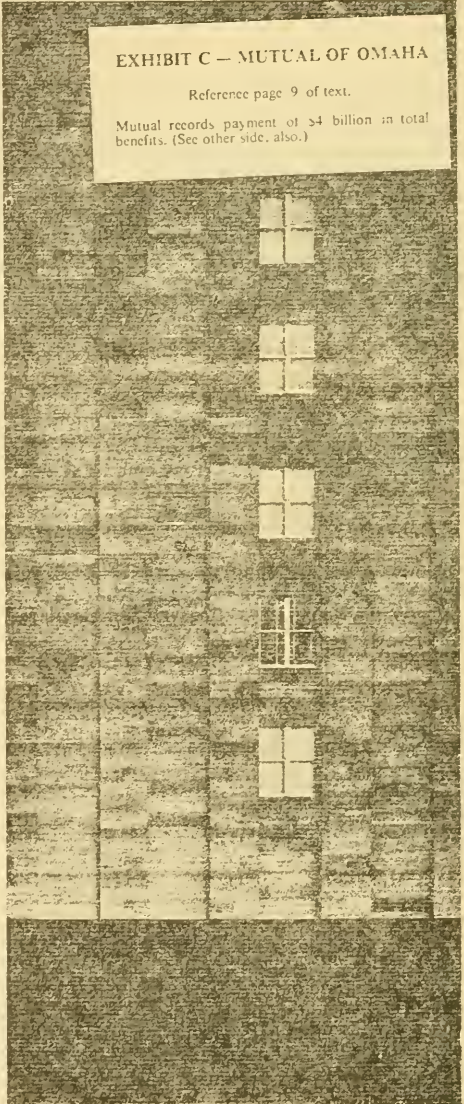


1968 "Three billion dollar" policyowner Glen Graham, New York businessman, has used his policy's rehabilitation feature. With the Grahams — Manager John Risko (far left) and agent Sid Hartman (second on right).

EXHIBIT C — MUTUAL OF OMAHA

Reference page 9 of text.

Mutual records payment of \$4 billion in total benefits. (See other side, also.)



fourth billion

On Dec. 17, 1971, Henry Herrman received his 35th consecutive monthly "paycheck" from Mutual of Omaha. This one, however, was something special — representing Mutual of Omaha's payment of **four billion dollars** in benefits to policyowners.

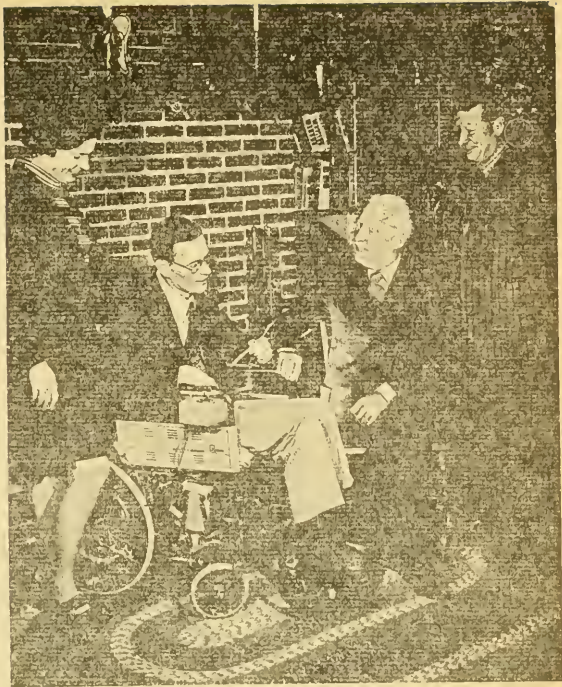
Chairman V. J. Skutt and General Agent Ed Boyce and his associates visited the Herrman family in Hays, Kansas, to present the check that marked a milestone unequaled by any other company in the individual and family health insurance field.

Before multiple sclerosis forced his retirement in 1969, Mr. Herrman was a successful corporate attorney. Although he can no longer practice law, he is still very much a success — as a husband, a father, a breadwinner.

And Mr. Herrman gives a good part of the credit for his present-day success to what he calls his "*Mutual of Omaha Self-respect Insurance.*"

"The one thing that could have destroyed me," says Mr. Herrman, "would have been loss of my self-respect. But with the help of my Mutual of Omaha income protection, I can say I am supporting my family and keeping my pride.

"I never met anyone from Mutual of Omaha I didn't like. And my deep gratitude goes, also, to the Kansas Bar Association for their wisdom in making this broad-coverage Mutual plan available to its members."



Top: Mr. and Mrs. Herrman receive the "four billion dollar" check presented by Chairman V. J. Skutt and Edward M. Boyce, general agent for Mutual in Western Kansas.

Right: The Herrman family with children Margaret, Henry Jr., John, Judy and Patty.



2

EXHIBIT E—MUTUAL OF OMAHA

(Reference page 13 of text.)

Report on several Mutual of Omaha Criss Award recipients.

Dr. Thomas A. Dooley Receives Criss Award for Outstanding Medical Achievement

EXTENSION OF REMARKS OF HON. RICHARD L. NEUBERGER, OF OREGON

In the Senate of the United States, Monday, January 11, 1960

Mr. NEUBERGER. Mr. President, in 1950 the Mutual of Omaha Criss Award was established by V. J. Skutt, president of Mutual of Omaha, in honor of the late Dr. C. C. Criss, founder of the company. The award consists of \$10,000 and a

gold medal, and is presented to the individual or individuals who, in the opinion of a distinguished board of judges, has made an outstanding contribution to public health and or safety. This board of judges includes Dr. _____, Mayo Clinic, who services as chairman; Lt. Gen. (Ret.) James Doolittle, chairman. Space Technology Laboratories, Inc.; Irene Dunne, actress; Henry Ford, II, president, Ford Motor Co.; Philip M. Klutznick, honorary president, International B'nai B'rith; William L. Lawrence, science writer for the New York Times; Harold Lloyd, actor; Don McNeill, radio personality; Dr. Louis M. Orr, president, American Medical Association; Dr. Thomas Parran, president, Avalon Foundation; Howard Pyle, president, National Safety Council; A. E. Stoddard, president, Union Pacific Railroad; and _____ Wallace, editor, the Readers Digest, all of whom have made outstanding contributions to public health and/or safety.

RECIPIENTS OUTSTANDING

Drs. Philip S. Hench and Edward C. Kendall were the first winners of the award which they shared jointly for their work in the development and use of cortisone, a drug which has great value in the control of arthritis. The second award went to a man distinguished in a number of fields, the eminent medical editor of the New York Times, Dr. Howard A. Rusk. The award was given for his outstanding success in rehabilitating the physically handicapped. In 1954, Mr. W. Earl Hall, editor of the Mason City, Iowa, Globe-Gazette, and past president and member of the National Safety Council, received the Criss Award for his distinguished work in the area of safety education. In 1955, the world famed Dr. Jonas E. Salk received the award for his selfless contribution to the development of a vaccine against polio.

Mr. President, on November 10, 1959, this distinguished group of men was joined by Dr. Thomas A. Dooley, the American doctor who has devoted his career to caring for stricken natives in the jungles of Laos and Vietnam.

I have spoken before in the Senate of the humanitarian dedication of Dr. Dooley, and I have written in magazines of this great American's courage, his skill, and tender care. Here is a man, now only 32, who has become the symbol of lifesaving, selfless Americans. He is the antithesis of "The Ugly American." His good deeds have helped conquer the barriers of custom, language, and hate—good deeds that made him become, as the President of Vietnam said, "Beloved by a whole nation" Dr. Dooley is truly a great person.

Mr. President, Dr. Thomas A. Dooley is the type of man whom our country needs for its ambassadors abroad—indeed, he is the type of man whom all humanity needs.

The Milwaukie Review, of Milwaukie, Oreg., on November 19, 1959, published a very thoughtful and eloquent editorial discussing Dr. Dooley's outstanding medical achievement, and his receipt of the Mutual of Omaha Criss Award. I ask unanimous consent, Mr. President, that the editorial from the Milwaukie Review, entitled "Another Tom Dooley," be printed in the Appendix of the RECORD.

There being no objection, the editorial was ordered to be printed in the RECORD, as follows:

ANOTHER TOM DOOLEY

Not too long ago there was a maudlin ballad about one Tom Dooley who was about to be hanged. Teenagers adored this character. His praises were heard wherever a jukebox blared, in adoration that was never clear. This teenage idol was a killer—and stupid, to boot.

This week another Tom Dooley should have become the idol of young people everywhere. In one place, he already is. In far off Laos, young Tom Dooley, now only 32, and 27 when he first came as a naval medical officer to the Orient, has become the symbol of life-saving, self-less Americans. He is the antithesis of the "ugly American."

Not financed by the Government, in fact at first scarcely financed at all, Dooley's outpost medical aid station in the tropic, disease-infected wilderness of Asia, became the hope of life itself for men, women, and children otherwise condemned to a hideous and inevitable death.

Dr. Dooley is an angry man. A young, ordinary, ambitious graduate medical student, he did a bitter internship in the rigors of the Korean war and its aftermath of refugees, of flood, famine and disease. He couldn't forget the misery, the need, the swollen, dying children. He went back and stayed. With modern medicine

and with his own talent and that of his recruited associates, he performed miracles.

This week, young Tom Dooley, M.D., received a coveted award. An award received in the past by such as Jonas Salk. It was the Criss Award of the Mutual of Omaha Insurance Co. for outstanding medical achievement. Young Dr. Dooley had thought he would have to use the \$10,000 he received to pay for his own recent cancer surgery, but that was subsidized. So he contributed it to another outpost in the wilderness, Africa.

Albert Schweitzer told Dr. Tom Dooley when he was so honored, "All the world should love you for what you do."

Hey, kids, how about this new Tom Dooley?

EXHIBIT F—MUTUAL OF OMAHA

Mutual of Omaha supports health care education—Commendation letter from Creighton University (Reference p. 14 of text)

CREIGHTON UNIVERSITY,
Omaha, Nebr., April 7, 1972.

Mr. V. J. SKUTT.

Chairman and Chief Executive Officer, Mutual of Omaha—United of Omaha, Dodge at 33d, Omaha, Nebr.

DEAR MR. SKUTT: It seemed appropriate to me that the news release on the Criss Institute of Health came at the same time we were preparing our list of Mutual and United employees' gifts to Creighton for matching purposes by the Company. Although it was not planned that way, it once again pointed out to us the debt of gratitude Creighton owes to you, your individual officers and employees, and the Mutual of Omaha organization itself.

As a former Regent and a present Director of the University, you know firsthand the problems that faced our School of Medicine a few short years ago. Facilities were obsolete and inadequate, the number of full-time faculty was well below standards, and the operational budget was far too low. If that situation had continued to prevail, there is no doubt in my mind that the School of Medicine would have lost its accreditation and inevitably would have had to close.

Beginning with our New Goals campaign, the exceptional support rendered by your company and the people associated with it, has enabled us to completely reverse this direction. This support has continued through our current Centennial Thrust effort. In place of an antiquated building, two new structures now house our Medical School and a third one is in the advanced planning stage. Also on the drawing boards is a new teaching hospital. Barring some unforeseen event, these two structures could be under actual construction in the not-too-distant future.

At last year's commencement, we all looked with justifiable pride upon the 69 new physicians that were graduated. As soon as their internships and residencies are completed, they will take their place in society delivering quality medical care. When one considers the shortage of physicians in the nation today, it would have been tragic, indeed, if we had had to close our Medical School. When you consider the fact that, thanks to the new facilities, the entering freshman class has risen to 90, the potential loss of future physicians takes on even greater proportions.

In any true summation of the contributions of your organization and the people associated with it, Mr. Skutt, we must not overlook the many hours of time that have been freely given to us in many complex projects. Your medical staff has rendered invaluable technical advice as our Health Maintenance Organization plans take positive shape.

I could go on at length, citing many other examples of assistance, but I feel that the point has been made. There is no doubt in my mind that the Mutual of Omaha Organization has made a significant contribution to the whole area of Health Care education.

For all of us at Creighton, may I take this opportunity to express a heartfelt "thank you"!

Sincerely,

JOSEPH J. LABAJ, S.J.,
President.

[From the Omaha World-Herald, Omaha, Nebr., Friday, Mar. 17, 1972]

PAGE 3 OF EXHIBIT F—MUTUAL OF OMAHA

Press reports on Mutual of Omaha's contributions in the areas of Health Care Education and Health Maintenance Organization plans.

C.U. PLANS RESHUFFLE TO EDUCATE MORE DOCTORS

(By Mary McGrath)

Creighton University hopes within a few years to educate more doctors and other medical specialists and do it for less per student and in a shorter time.

Among the proposals:

—Set up a basic health science school where doctors, dentists, pharmacists and other health specialists would get their preliminary training.

—Combine three planned medical buildings into one joined to a \$10-million dental school now under construction.

"We hope to put together educational programs which could become a pattern for the nation," said Dr. Robert Heaney, vice president for health science, at a Friday press conference at C.U.

Final determination of curricula revisions will come from a study which Creighton hopes to carry out and implement during the next three years, Dr. Heaney said.

Grant Sought

The University has applied for a three-year \$559,682 federal grant to help pay for the study and implementation.

"Without federal help, it will take us at least 10 years," Dr. Heaney said. Creighton does not now have funds to pay for the additional manpower—including a full-time director and curriculum specialist—necessary to carry out the project, he said.

Existing health care and medical education problems, such as the physician shortage, have prompted Creighton officials to consider sweeping curricula revisions, Dr. Heaney said.

"Despite many examples of superb health care, the overall U.S. picture contains too many examples of excessive cost, inordinate delays and irregular quality," he said. "Health care costs have increased five-fold since 1950."

"I feel the inertia of the present system will yield to nothing less than radical restructuring of both educational programs and methods," he continued.

All in One School

Creighton's proposed new approach is based on admitting all health science students in a health sciences school where they would be taught common, basic courses. Specialty courses would be taught by professional schools, such as medicine or pharmacy.

Students could enter the health sciences school either directly out of high school or after taking some college work.

The basic idea, Dr. Heaney said, is to give each student as much education as he needs to function in his profession, but not to require more.

"The job of the ophthalmologist is to care for your eyes. Why does he need to have a detailed knowledge of the anatomy of the foot? But his present education includes it," he said.

The new approach, teamed with early specialization, should cut time from the required school years, he said.

Creighton planners estimate that a physician who is a clinical specialist could complete his work in eight years, compared to the 12 now generally required.

The flexibility in the proposed curriculum would make it easier to fit a course to the interests and backgrounds of individual students, including those who are disadvantaged, Dr. Heaney said.

Students with financial problems also would be helped by plans to offer such programs as the two-year nursing degree or physician's assistant.

A student could complete such a program and then work either full or part-time while completing a degree, if he wished.

Plans also call for adding programs for additional types of health professionals, such as midwives and nurse specialists.

Limited degrees are being considered. Such a degree, Dr. Heaney said, would give a person a broad understanding of a field, such as medicine, but only qualify him to practice in a limited area, such as obstetrics.

Other offerings may be programs which cross the lines between disciplines. Thus, you could be a lawyer with a medical background or a doctor with a legal background.

As Creighton educates new types of health professionals, they will join the ranks of those providing services to patients, thus helping change the pattern of health care, Dr. Heaney said.

PAGE 5 OF EXHIBIT F—MUTUAL OF OMAHA

CREIGHTON PLANS TO CONSOLIDATE BUILDINGS

Two years ago Creighton University drew up a development plan which showed a hospital and three other new medical structures west of the North Freeway. Today that part of the plan is outdated, said Dr. Robert Heaney, vice president for health sciences.

What has outdated it are plans to make major revisions in the university's health sciences curriculums and closely integrate education with patient care, he said.

Under discussion is a structure housing hospital facilities, classrooms and doctors' offices. The shape is yet to be determined.

The building would be joined to the \$10 million dental school, now under construction.

The area in which Creighton is constructing its medical buildings is bounded by the freeway, Twenty-eighth Avenue, Cass and Burt Streets.

Dr. Heaney said construction will require clearing the southern part of that area. The university owns most of the property, he said.

The hospital will be built by Regional Health Care Corp., a separate group formed by Creighton and St. Joseph Hospital. The hospital, which will replace the present St. Joseph, should open in 1976.

The dental school is scheduled for completion in 1973.

Dr. Heaney said a federal grant application will be filed in late summer for funds to help construct a building which will span the North Freeway and link the two parts of the campus.

This building would contain a library and offices. It also may have some parking. Dr. Heaney said a cost estimate is not available.

Creighton has not obtained air rights over the freeway.

Medical Complex: Criss Institute

Creighton's medical complex is being officially named the Criss Institute for Health, it was announced Friday at a press conference at the university.

The name honors Dr. C. C. and Mable L. Criss for major financial contributions to Creighton's health projects.

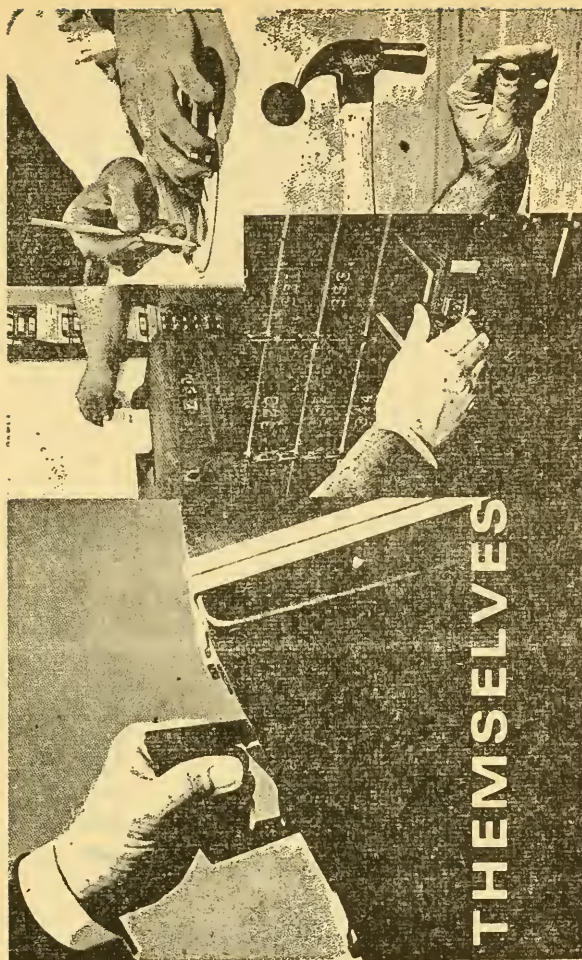
Included under the institute umbrella will be present and proposed classroom buildings, such as the medical and dental schools, and a yet-to-be-built hospital.



EXHIBIT D — MUTUAL OF OMAHA

Reference page 12 of text.

Rehabilitation booklet shows case histories of a few of the many policyowners helped by Mutual of Omaha's Rehabilitation Policy Provision.



HELP THEMSELVES

THEMSELVES

..... HELP

Mutual of Omaha has helped many disabled policyowners return to productive lives. Some of these people have found their new way of life more fruitful than before disease or injury struck.

Advanced medicine and treatment, rehabilitation techniques and modern devices result in job placements that were an impossibility just a few years ago.

rehabilitation program respects the individual's free choice of attending physicians. We also respect the doctor's professional opinion and guidance in all programs. Written agreements can be arranged as guarantees of continued monthly insurance benefits during an approved program. Talents and tolerances are weighed in accordance with physical and educational limitations.

Our experience tells us that disabled policyowners can benefit the most through the local use of private, state or federal facilities. Programs may involve "on the job trials," vocational training, business ventures, special medical treatment and therapy, schooling, and use of special prosthetic and orthotic devices.

We firmly believe our disabled policyowners have values which can be developed. We are encouraged in this belief by the hundreds of outstanding examples of courage and determination demonstrated by them. A few such stories of personal courage are related on the following pages.

Our goal will always remain the same to help these people help themselves.

John J. Hess
Director of Rehabilitation

..REHABILITATION

He learned that he could lead a normal life of "ordinary physical activity," but he should not return to the heavy duties and stress of driving a bus in traffic or the possible sudden excitement of a night security guard.

Mr. King talked to Joseph several times, and arrangements were made through the Maryland State Rehabilitation Commission for a job evaluation and possible placement. It was determined that he was suitable for a course of training in machine set-up operation. This was not heavy work, and his doctor gave approval.

During the training and schooling, assurance was again given by Mr. King, along with our usual moral payments under his disability contract. The freedom under this Rehabilitation Agreement reduced his worry, thus giving him more freedom to concentrate on his training, which eventually proved successful.

Joseph Stenger held two jobs. He was a bus driver and a security guard until it happened — a sudden heart attack and immediate confinement to the hospital. This was an abrupt and painful halt for all work and physical activity.

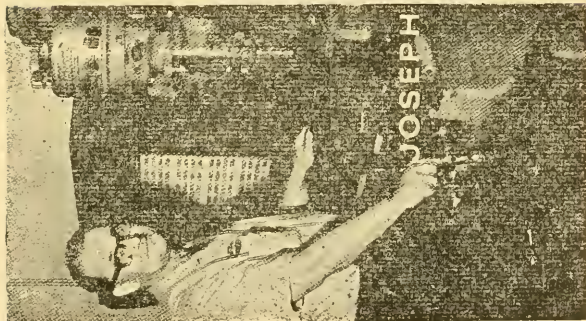
Joseph Stenger's doctor warned him that 276 pounds was just too much weight, but it was tough to maintain a constant diet and handle two jobs. Now that it happened, he wondered what he would do. What about the wife, the three children, the house, and the many things that go into the everyday life of a working father.

Joseph Stenger is no quitter. He accepted the challenge of learning about his tolerances through the encouragement of the doctor and Mutual of Omaha's claims representative, Pearce King.

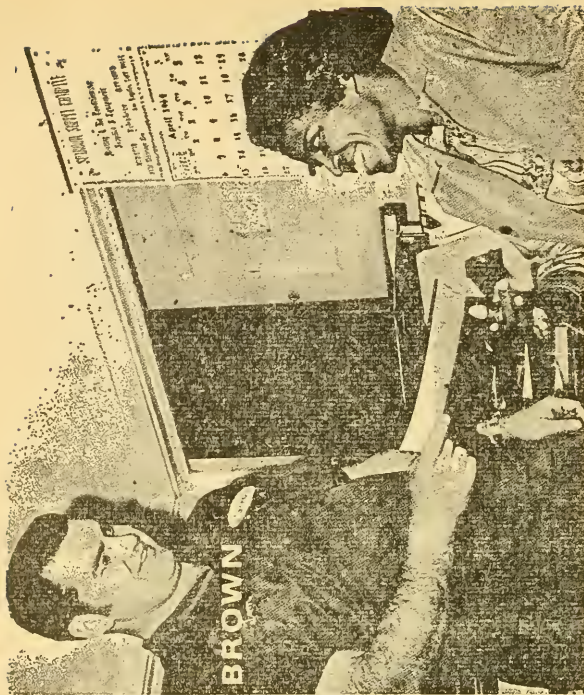
The Maryland Heart Association was contacted, and a complete evaluation was made setting forth the limitations.

STENGER...

is now enjoying his work at a new occupation. He is a courageous family man that should be an example to others. Shortly after starting his new job at the metal products company, he wrote a letter to Mutual: — "Now I've been working for two weeks, I've drawn my first paycheck since I first got sick in December 1967. If it wasn't for your company helping me, I don't know where I would be today. Thanks a lot, Joseph H. Stenger."



JOSEPH STENGER



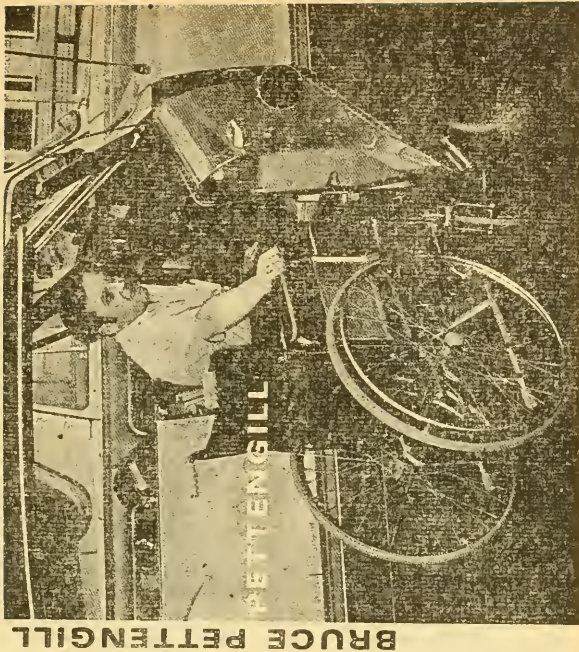
LUCY BROWN

Rehabilitated Quadriplegic Miss Lucy Brown of Los Angeles, California, was a sewing machine operator when she obtained her Mutual of Omaha income protection policy in March 1959. Two months later this 33-year-old woman was in an auto accident, receiving injuries that made her a quadriplegic.

.... LUCY

Miss Brown was paid a monthly income during her lengthy recovery and benefits were continued when she was able to enroll in a trade school while still confined to a wheel chair. Under her Mutual of Omaha rehabilitation program, the cooperation and encouragement of her doctor, the Company's claims representative, and the State Rehabilitation counselor, she graduated in 1965 with a degree in tax accounting and book-keeping.

Because of her determination to be independent and work again, she has been employed steadily in her new vocation as a bookkeeper and secretary for an industrial contractor. Lucy's smile, as she accepts her paycheck from her employer, Thomas J. Markos, expresses her happiness over her ability to lead a normal life though handicapped.



BRUCE PETTINGILL

Take a 24-year-old draftsman and add a passion for skiing and the results can often be disastrous.

In this particular case, they were. A back and spinal cord injury resulted in paralysis of both legs. This young man had a problem. How could he get back and forth to his work? How could he perform up to his former level of work? How could he convince his employer — a large manufacturing company — to give him an opportunity?

... BRUCE

Between his doctor and our claims representative we convinced the young man and his employer that the opportunity should be given. A collapsible wheel chair and hand controls for the car solved more problems. A trial work agreement solved the most important problem — money.

Fourteen months after the accident, the Insured was ready to make his comeback. Within five months this young man had convinced his employer — and more importantly, himself — that he could perform again at his old job.

One last note — the young man took on an added job after returning to work full time. He was married and certainly this is the ultimate in rehabilitation.

When a 25-year-old truck driver and logger, accustomed to the rigors of outdoor life, is suddenly faced with the loss of a leg, the future might seem bleak! Not so for Roy D. Cook of Quincy, Illinois.

Three days after his Mutual of Omaha policies were issued, Roy was seriously injured when a log fell off his truck and struck him on the left leg. Roy's leg had to be amputated and he was no longer able to work as a trucker in the logging business.

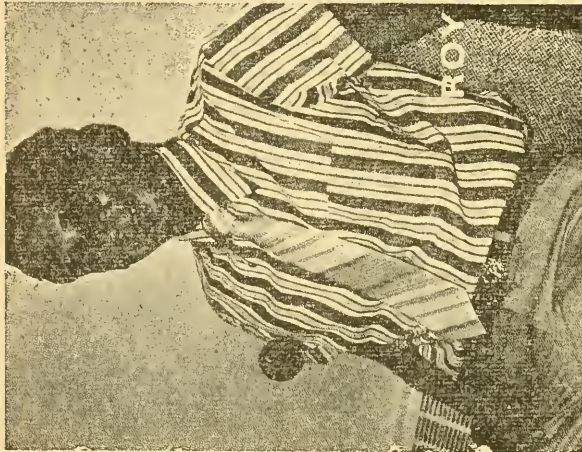
Roy was contacted by Mutual's claims representative, Edwin Adams, and the Company's rehabilitation program was explained. Through a coordinated effort of Edwin Adams, the doctor and counselor, a vocational program was set up.

After months of hardship and training Roy started work in a new occupation as an office machine repairman.

Loss of a leg is no handicap to Roy since he proved to himself through determination and grit that he could lead a useful and productive life.

D. COOK.....

ROY D. COOK



Not only does Mutual of Omaha help rehabilitate its policyowners, but it believes in employing handicapped persons, too, both in the field and the Home Office. These persons make excellent employees and are considered on the same competitive level as all the other employees.

MUTUAL

Other of our employees are deaf, use crutches and braces, may be spastic, or just have one arm, but such physical impairments do not hinder their thinking ability.

Dan Hoewet, 29, joined Mutual's Computer Systems and Programming Department in 1965. He is a valuable programmer in the vast maze of Mutual paper work and statistics.

Dan loves sports and books and enjoys attending football games. Though totally blind, he "watches" the games by feeling the excitement in the air along with a good announcer's description on the radio. By reading, Dan means "listening to someone read a book or magazine on records. Too, Dan even bowls a little.

MUTUAL OF OMAHA HIRES

Susan Costanzo, while confined to a wheel chair, handles her share of the load in the Stenographic area. Susan was stricken with polio while in the fourth grade but graduated from high school a straight "A" student. Promoted four times since she started with Mutual in 1961, she is now a unit supervisor.



MUTUAL OF OMAHA HIRES FOR ABILITY

FOR ABILITY



A PARTIAL


DISABILITY


Laminectomy
Amputation, Right Leg
HCVD, Heart Disorder
Shoulder Disabled
Heart Disorder
Paraplegia
Heart Disorder
Injured Shoulder,
Urethral Stricture
Heart Disorder
Quadruplegic
Amputated Leg
Amputated Arm
Amputated Leg
Multiple Injuries
Knee Injury
Veinous Insufficiency
Laminectomy

LIST OF CASES REHABILITATED TO PRODUCTIVE LIVES

FORMER OCCUPATION	NEW OCCUPATION	DISABILITY	FORMER OCCUPATION	NEW OCCUPATION
Truck Driver	Bookkeeper, Tax Work	Crushed Spinal Disk	Transport Operator	Salesman
Assembler	Bench Worker, Rehab. Center	Heart Disorder	Farmer	Heating and Oil Business
Restaurant Owner	Real Estate	Paraplegia	Surgeon	Attorney
Tile Setter	Truck Driver, Deliveryman	Paraplegia	Terrazzo Layer	Draftsman
Routeman	Bank Teller	Heart, Arthritis	Laundry Owner	Bookkeeper
Draftsman	Checking Engineer	Disorder, Spine, Knee	Dairy Farmer	Insurance Agent
Bus Driver	Machinist	Fractured Heel	Timberfaller	Insurance Salesman
Factory Worker	Radio Broadcaster	Heart Disorder	Appliance Salesman	Tax Collector
		Ruptured Disk	Plaster Tender	Draftsman
		Back Disorder, Kidney	Route Salesman	Personnel Work
		Amputated Left Leg,	Machine Operator	Instrument Repairman
		Right Foot	Steel Worker	Machine Accessories
Hod Carrier	Barber	Fractures and		Business
Sewing Machine Operator	Bookkeeper	Lacerations, Both Hands	Service Manager	Electronics
Fireman	Civil Service Post	Disorder, Spine	Drill Press Operator	Clerk-Typist
Welder	Swine Raiser	Amputation, Leg	Furnace Dealer	Hardware Store Owner
Carpenter	Insurance Agent	Paralysis	Union Representative	Theater Manager
Woodcutter	Real Estate	Heart Disorder	Carpenter, Farmer	Rehabilitation Counselor
Counterpane	Bookkeeper			
Beef Boner	Real Estate			
Truck Driver	Dispatcher			


REHABILITATION HIGHLIGHTS ..


 Mutual of Omaha Criss Award presented to Dr. Howard A. Rusk for his outstanding work in rehabilitating the physically handicapped. Dr. Rusk is a world-renowned expert on rehabilitation and associated with the Institute of Rehabilitation Medicine — New York University Medical Center.

 Mutual of Omaha Criss Award presented to famous film star William Gargan for dynamic leadership and outstanding contributions in rehabilitation, especially people disabled by cancer of the larynx.

 Mutual produces film "Biggest Bridge in Action" as an aid for the President's Committee on Employment of the Handicapped.

 Mutual of Omaha receives the "Employer of the Year Award" from the Omaha Mayor's Committee for Employment of the Handicapped.

 Mutual of Omaha presented Distinguished Service Award by President Dwight Eisenhower's Committee for Employment of Physically Handicapped for encouraging and promoting employment of the physically handicapped.

 Mutual presents a Public Service Award to Lt. Frank Ellis for his courage and example to others. Lt. Ellis lost both legs in a plane crash, yet a miracle of self-rehabilitation proved to the United States Navy he could parachute jump and again pilot a plane.

.. MUTUAL OF OMAHA

More than 9,000 representatives

Over 500 local offices

Licensed in all 50 States, District of Columbia, all Provinces of Canada, Great Britain, Puerto Rico, Panama, Canal Zone and portions of the West Indies.

STATEMENT OF V. J. SKUTT, CHAIRMAN OF THE BOARD, MUTUAL OF OMAHA INSURANCE CO., OMAHA, NEBR.

Senator HART. You may proceed.

Mr. SKUTT. Thank you, Senator Hart, and thank you, Senator Hruska for those comments.

I am V. J. Skutt of Omaha, Nebr., chairman of the board of Mutual of Omaha. And seated with me, at my right, is Albert M. Hansen, who is senior executive vice president in charge of product and services for our organization.

Elsewhere in the room are several of our fellow officers and associates. If there is anything that Mr. Hansen and I do not respond to properly, I'm sure that we can call upon them for some assistance.

We appreciate indeed the opportunity of participating in this hearing. We think that the information developed by your committee, Senator Hart, should be helpful in effectuating improvement in the delivery of health care for the people in our country. The important role of commercial health insurance in reaching this objective is something that we have tried to trace in the formal statement which you just recorded and which has been filed with the committee.

We endeavor to go into the genesis a little of the coverages as the companies were organized and developed through the years.

And I respectfully submit, sir, that any legislative action in this field should recognize the functions performed and performable by the commercial insurance carriers.

Much has and should be said on the part of those unable to receive prompt medical care. This is due to inaccessability of prompt professional services for financial or other reasons. As we totally deplore this situation and vow to improve it, we should not ignore the great progressive services in medicine and health care, nor should we disregard the means available for financing such services developed in recent years.

You have the figures to show this progress from other testimony in the hearing. May I respectfully submit that for every hardship case that has been or could be presented to demonstrate some inadequacy in the delivery system and means of financing it, hundreds of cases showing the benefits therefrom could probably be produced.

All of the instrumentalities involved in health care, such as medical, nursing, and associated professions helping to provide it, and the insurance and service institutions, together with the Government helping to finance it, have been responsible for this great progress.

Just as we all share in its progress, gentlemen, we must also share the responsibility for its shortcomings and weaknesses. Nor should we be satisfied until all the ill and injured of our country know that they will receive the necessary attention, regardless of their financial condition or their whereabouts.

The following statement was made by the chairman of this committee at the opening of the hearings on the 24th day of February 1970. May I say, Mr. Chairman, that I am covering briefly some of the matters in our field report, but I'm trying to pick out those which I thought would be of most interest to the committee.

At that time, you said:

Now, inevitably, when we undertake hearings like this, because the record can be finished only at the end of the hearing, and in the evolutionary process of building a record, fingers appear to be pointed at one or another segment of the problem. Understandably, the person to whom the finger is pointed feels that there is an element of unfairness in that.

That's the end of that portion of your statement.

I do not propose this morning to point the finger at anyone—the doctors, the insurance companies or the Government. I do say we all should endeavor to do a much better job. We should sit down together, as in a sense you are doing in these committee hearings, and review what has been accomplished and what remains to be done to give all of the people in our country proper medical care regardless of financial condition or location.

I believe that, to do this, we must have pluralistic participation in order to achieve the best results.

Let me give you an example. In 1956, Public Law 569 created the CHAMPUS program—that is the civilian health medical program for the uniformed services.

Under it, the commercial health insurance companies and Blue Cross would administer, at cost—at cost—the program which is financed by the Federal Government.

Mutual of Omaha offered its services, after considerable thought and some precise information on the need for this program, particularly in the Air Force. It was assigned 17 States; the balance of the country was assigned to Blue Cross.

Figures filed by the Department of Defense in its annual reports to Congress show that for the first 8 years of the operation of CHAMPUS, the cost to the Government was 38 percent less for the actual service rendered by Mutual of Omaha. The exact figures are in the formal statement and the exhibits filed with you.

This is cited only as an example of comparative performance incentive and competition at work, which could not possibly exist under any monolithic program.

Now, the first question submitted in your communication of March 15 asks about the sufficiency of the return in individual or group accident and health insurance. This question, like many general questions, calls for an opinion: "What is a sufficient amount?"

Mutual of Omaha paid benefits to more than one and a quarter million persons in 1971 alone, and that does not include, of course, the service through CHAMPUS and Medicare. The amount was important to these policyholders in all cases; we hope it was sufficient in most cases to meet their needs.

Naturally, a higher percentage of premium is returned in group cases, than in individual. That doesn't mean a higher amount; it just means that a higher percentage of the premium is returned—if you can call it a "return"—in group cases than in individual policies.

The latter involves—that is, individual—involves a multiplicity of transactions and personnel. This is a cost factor, but at the same time there are benefits beyond the direct return which should not be overlooked.

Also a comparison of the actual costs of production of other necessities, such as food, automobile, et cetera, shows a great differential, compared to the price paid by the consumer.

Are the consumers in the field of tangibles getting a sufficient return for their dollar, when the actual product costs less than 60 percent of the retail price? Or, in the field of intangibles, even such as title insurance or bail bond insurance, where the buyer seldom gets any direct financial return for his premium; he presumably has received a sufficient return in the way of protection that these contracts provide him.

We must remember, too, that the purpose of these forms of protection, of coverages—health insurance, and so forth, is protection and not investment, and some of the return is the knowledge on the part of the policyowner that when illness or injury strikes, he will have these benefits.

But there are other services rendered which are important in determining whether or not the return for the premium paid is "sufficient" as used in the question. Many of these services are difficult to evaluate precisely. However, they are most valuable to the policyowner and the public, generally.

The rehabilitation program of Mutual of Omaha is an example. It was inspired by the late General Melvin Maas, a disabled policyowner of our organization, who joined our board of directors.

He also served as Chairman of the President's Committee on the Physically Handicapped under both Presidents Dwight Eisenhower and John Kennedy.

Experience with this program demonstrates that the request for health care services over a continuing period of time is sometimes as much attributable to the nature and character of the individual involved as it is to the medical diagnosis itself.

We need not look beyond this Capital City here, for an example. A great example is Franklin Delano Roosevelt, struck down by crippling polio early in his career—he could have been a patient, an invalid, for the balance of his life; yet he went on to achieve and fulfill the obligations of the most important position in our country for the longest period in its history.

There are other examples of people who have overcome serious illness or injury, thus avoiding further extended hospital and medical care. However, it is probable that there could be many more with additional emphasis on rehabilitation.

Now, there is a great deal of discussion and comment, I noticed, in the proceedings of this committee, on the adverse effects of overutilization on costs, and yet I have found an absence of any discussion concerning the importance of rehabilitation to help meet that problem.

Other activities relating to the sufficiency of the return, in addition to the rehabilitation program, may be found in the field of research for greater health and safety, and I am speaking in these instances of Mutual of Omaha. I can't speak for the industry on some of these matters.

Mutual of Omaha in 1950 created its Criss award, unique in its field. The award has been given to Drs. Hench and Kendall for their work in the development of cortisone, Dr. Howard Rusk in the field of rehabilitation, Dr. Jonas Salk for the discovery of the polio vac-

cine that bears his name, and Dr. Tom Dooley for his efforts with the medically indigent and, most recently, to former actor Bill Gargan, who had cancer of the throat and has done so much in the field of cancer rehabilitation.

But we realize, of course, that the basic test of the sufficiency of the return, as far as the policyholder is concerned, is what he gets back in direct benefits. That is vital, of course.

During 1970, Mutual of Omaha returned 22 percent more of its earned premium income to policyholders in benefits on individual policies, than the combined average of the next 24 companies in this field.

Here, then, is another example—and is cited for that reason only—of the advantages to policyowners and public of a pluralistic or competitive systems, vis-a-vis a monolithic program.

In this connection, may I respectfully call your attention to the cases pointed out in the exhibits filed with our written statement, as Mutual of Omaha passed its various milestones of billion in benefits.

This began in 1958. We passed the first billion, after 49 years in business, and the \$4 billion was reached last December.

The first case is a young family in Michigan. It just happened Senator—I don't want you to think that we put in this example from Michigan because you are chairman of the committee. This happened in 1958, when this particular case carried us over the first billion.

This first case was a family by the name of McMunn, at Ann Arbor, whose picture is in the exhibit with his wife and daughter. Of course, we paid them—the records show here 12 times since then for different benefits, including maternity and so forth.

The second case was a more serious illness. That was a machinist in Connecticut. He had an illness condition from which he is still suffering, and so far he has been paid over \$43,000 in benefits.

And 4 years later, the \$3 billion figure was passed, by a businessman in New York who utilized the rehabilitation feature of his policy, to which I referred earlier.

Then in December of 1971, the \$4 billion figure was reached. This case involved an attorney in Kansas who was stricken with multiple sclerosis at the age of 39. His comments are found in the exhibits.

All of these payments above referred to are available to the policyowners to use as they see fit. In fact, all of the benefits paid by our organization are paid to the policyowner to use for the hospital and doctor bills, as well as living expenses, for their children, or whatever.

And as we see so many examples of our service of this kind, we are inspired to greater efforts to fill the gaps which have been discussed and pointed out at these hearings.

On the other hand, we must say that there has been great progress, because it is a fact, both with our organization, the industry, and in the Government, in helping to meet these problems.

We are involved, for example, in the development of preventive programs and health maintenance organizations. Either directly or indirectly, we are involved in over a dozen HMO locations throughout the country today.

And the people of our organization have total involvement in the preservation of the Medical College of Creighton University. They also support the new programs to provide more doctors, and to graduate them more quickly through an intensified curriculum.

I notice, too, and happily that the Government has stepped up helpful programs. One of its efforts that came to our attention just this week was providing 150 physicians and other trained medical personnel to medically underprivileged areas under the 1970 Emergency Health Personnel Act.

It was a pleasant surprise to see that the Government could call on this professional assistance to meet an emergency under existing law. It suggests the desirability of making sure that before further legislation is adopted, that we verify that all existing authority is fully utilized and that careful analysis be made as to all of the various programs presently available.

The medical profession appears to be aware of the necessity for cooperating in the education of more doctors, nurses, and other associated personnel as rapidly as possible.

It has been said they have been a little slow to get to this point, but I believe they recognize it now. They also should make every effort to see that unnecessary hospitalization and medical expenses are avoided. After all, it is the doctors and not the insurance companies or the Government who put a patient in the hospital.

On the other hand, looking at this reciprocal responsibility, insurance institutions should do more in providing outpatient and ambulatory benefits to avoid the necessity of hospitalization.

There should be more emphasis on this and in the case of Mutual, there is. I repeat—there should be, and in the case of Mutual of Omaha, there is—more emphasis on out-of-hospital benefits for that very reason.

The Government can encourage the efforts of the insurance institutions, and particularly the public itself, by considering such programs as allowing tax credits and other inducements to people to provide for their own coverage if possible.

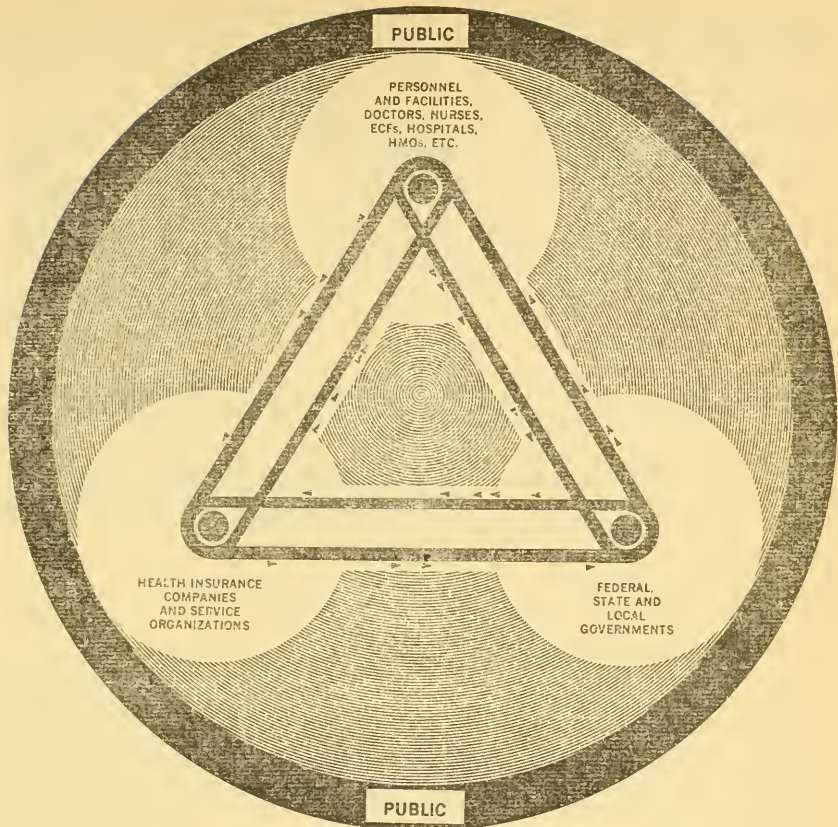
Also, it can continue to encourage the insurers and the medical profession to put more emphasis on rehabilitation, as I have mentioned, to eliminate unnecessary hospitalization, return more people to productive lives.

This can be helped by some of these programs. Finally, again, everyone in our country, regardless of financial condition, race, occupation, or location, should all have accessibility to health care.

The consciousness of the need for such assistance by all three segments involved in meeting the need—the Government, the health care profession, nursing, doctors, and associated personnel, and the insurance, or service institutions, including of course the Blue Cross. These three segments must work as a team in getting this job done.

I have here, in the interest of brevity, a small and rather crude diagram which we drew up quickly to try to illustrate the interdependence of these—or three segments, rather, in trying to meet this problem.

There you see at the top the deliverers, the purveyors, of health care—the hospitals, nursing homes, the medical profession, and so forth.



Now, that's in the top of the diagram. (Diagram slipped off easel.) I hope that that is not symbolic of what is going to happen here in the program. I thought that the diagram was quite appropriate.

Now, going from one to the other, on your left as you look at it, the insurance institutions and service organizations, and on the right, the Government facilities, both Federal and State, as well as local.

Those lines going from one to the other are representing a conduit, or representing pulleys, in a sense, and, of course, the outside circumference is the public that touches all of those three.

It is supposed to illustrate the interdependence and the relative functions of those three segments that I have referred to.

Those are supposed to be pulleys that are rotating, bringing this protection and this service to the respective groups, and then ultimately to the public.

One of our associates who helped prepare it rather hurriedly—we just put this together today—said that we are all “pulley-ing” together. But that is his statement. I thought that it was kind of appropriate.

On that basis, Senator, I feel that we can accomplish the objectives as set forth by the committee, and to which all of us subscribe—of improving the delivery of health care to the people of our country.

I do not think you can do it with the elimination of any one of those three segments pictorialized in this diagram because every one of them have a vital function.

It seems to me that it would be the height of folly to consider scrapping or even reducing the functions and responsibilities of the health insurance personnel of this country such as the dedicated people in our own organization. I might say, if I can do so without being immodest, because I have only had a small part in it, but I would say that the people in Government, the people in business, people perhaps in all walks of life, should be happy that there is the Mutual of Omaha in this country.

I can assure you that the services of our people are going to be available to continue to carry out what they feel is an important function.

I would like to just conclude this, Senator Hart by going back to the balance of your statement at the opening of these hearings—I quoted the first part earlier.

The part that I have before me now says, "Be assured that before this record is closed," and I assume you are getting rather close to closing it, and that is the reason that I thought that this would be appropriate—

Before this record is closed, every segment that feels it has a story to tell in explanation of the factor it contributes to that spiraling circle will be heard, speaking of the costs, and so forth.

It is altogether possible that at the end we will have to acknowledge an understanding sympathy of a problem that everybody has; acknowledge that there is nobody without that in the field.

But the cumulative testimony will, I hope—and I am quoting—"encourage all of us in the business of delivering hospital care, to demonstrate an ability to respond to this kind of a problem with solutions, or a set of solutions, that will deliver the best of hospital care at the lowest possible cost."

I feel, sir, that a recognition of the distribution of responsibility, and a triangular, or a pulley approach to this solution, is responsive to your goal as so well expressed.

I thank you for the opportunity of presenting it to you this morning.

Senator HART. Mr. Skutt, I thank you very much. I think whoever dreamed up the pulley system yesterday did help us visualize the assured failure of our society to deal with health care until we beef up all of the elements.

Those of us on the committee have heard enough to realize we sometimes complain to insurance companies that they don't ride tough enough herd over hospital practices, and yet we realize that ultimately doctors make most of those decisions.

We quarrel with insurance companies because they provide inadequate coverage and they make it more difficult for the person to get in the hospital. Then we realize that the next witness is going to tell us about a bitter experience he or she had trying to get into a hospital because it was overloaded or the nurses were too busy.

We do develop an appreciation, I think here, an interrelationship, and really, the inability of any single element in that triangle to approach a completely satisfactory delivery system barehanded. It doesn't depend on anybody.

You put it on page 18. I was reading along with you.

It seems equally clear that the most ideal of systems can only be an effective blueprint during the immediate future. Until such time as the nation has sufficient manpower and facilities and adequate distribution of manpower to render the services, the ideal will remain a blueprint.

Mr. SKUTT. That is right.

Senator HART. But having made that acknowledgement, the committee will continue to put needles in the several segments of this system.

Mr. SKUTT. Fine.

Senator HART. Next sir, let me thank you and those associated with you for their very full cooperation with the requests which I know were burdensome. Also I want to thank you in that you had your statement so far in advance.

Thank you.

Now, included in some of the material that you gave us was a manual that included a direction to your personnel on the handling of settlements, specifically it's—no; it is not numbered.

If you have no objection, I will put the relevant three pages in the record at this point so the reader of the record can get a full appreciation of what we are talking about.

(Documents follow. Testimony resumes on p. 1220.)

SETTLEMENTS

BENEFITS DISPOSITION 9200

When you receive a request for benefits, there are four basic methods at your disposal for concluding the request:

1. Payment of the full benefits.
2. Compromise Settlement (payment of a portion of the benefits).
3. Rejection of request.
4. Rescission.

Although the majority of the requests you receive will be handled by full payment of the compensable benefits, it is necessary to discuss the remaining methods of disposition.

COMPROMISE SETTLEMENT 9201, S-9

A Compromise Settlement is an agreement reached between the Company or its representative and the Insured involving the Company's payment of an established sum to the Insured in return for his signed release of any additional or subsequent benefits due for the disability in question. Unless a bona fide question of fact or law exists, *do not* initiate a lump-sum settlement.

SETTLEMENT HANDLING 9202

After the auditor has completely and thoroughly documented the file and the circumstances indicating that a settlement is in order, refer the file to the benefits manager. The benefits manager should decide whether the file requires personal handling. If personal handling is necessary, refer the file to the field adjustor with a completed File Recommended for Personal Handling MU5618.

FILE RECOMMENDED FOR PERSONAL HANDLING 9203, MU5618

Be sure to use the proper release form:

RELEASE FORMS 9204, M6704, U6704, M6705, AND U6705

1. *Compromise Settlement Release Form M6704-U6704 or Compromise Settlement Release with Surrender of Policy Form M6705-6705*: These two forms are to be used in cases where a question has arisen regarding coverage under the policy of any application for benefits that has been presented. The validity of the policy itself is not necessarily questioned. Question may involve origin before or within 30 days, heart trouble within six months, etc., or may involve

the question of total disability or confinement. In other cases, there may be a question of misrepresentation, but for good reasons it is determined that the benefits should be compromised. The proper form to use will depend upon whether or not the policy is to be surrendered as part of the consideration for the settlement.

M6706, U6706, M6707, AND U6707

2. *Final Advance Settlement Release Form M6706-U6706 or Final Advance Settlement Release with Surrender of Policy Form M6707-U6707*: Both of these releases are used in instances in which neither the validity of the policy, nor coverage under the policy is questioned. These releases should, of course, be used only in those cases in which payment is actually made beyond the date of settlement, and at the request of the Insured.

M6708 AND U6708

3. *Full and Final Release Form M6708-U6708*: Use in all cases where validity of the policy is questioned and all liability under the contract denied.

HANDLING REFUND OF PREMIUM 9205, S-18, SD-90, MU1904

Many times the settlement of a benefits request will involve the surrender of the Insured's policy. On occasion, a part of the money paid the Insured will include a refund of premium paid in advance of the date of settlement. Accounting procedures dictate that we differentiate the refund of unearned premium from the remaining paid benefits either by indicating on the draft or the Field Adjustor's Report MU1904.

When confronted with situations involving policy surrender and premium refund, auditors and adjustors remember these guides:

1. Premium refund should be made by Miscellaneous Disbursement Draft M711-LU623 which shows that the payment represents a refund of premium under the policy.

2. If it is not practical to draw two drafts in concluding a settlement (one for the benefits paid and the other for the refunded premium), then include both benefits and premium payments with one benefits draft *provided* . . . 2.1 That the notation "Premium Refund" and amount is set out on the lower left corner of the draft stub immediately above the draft form number.

3. If the settlement does not include premium refund, it is not necessary to so state on the adjustor's report or the draft.

4. Where a policy is canceled through settlement, *immediately* advise the benefits manager of the office maintaining the PIC record on surrendered policy (if out of territory) so that any other pending benefits file can be clearly marked to show the cancellation.

5. Make a complete résumé of the settlement a part of the file.

6. Forward file to Home Office Benefits Service Administration Department *without delay*.

NOTE—On a surrendered policy, attach only the "Facing or Schedule Sheet" of the policy to the file. *Do not forward the entire policy.*

CONTINUANCE OF PARTIAL COVERAGE 9206, P-3

Often an Insured owning a basic loss of income policy with riders covering himself or dependents against medical, surgical or hospital expense will hesitate in making any adjustment in the contract for fear of losing some element of desired coverage.

This factor can be a bar to a benefits representative entering into an amiable settlement where a question of fact or law prevents final disposition of a benefits request. To resolve this problem, the following recommendations should be followed . . .

UNPAYABLE FILES

REJECTION-RESCISSION, 9210

A *rejection* is a denial of liability for benefits because the disability or loss is not covered by the terms of the contract.

A *rescission* is the voiding of a contract as of its issue date because of a *material* misrepresentation or concealment of fact by the Insured in his application for insurance (the application being part of the contract).

REJECTION HANDLING, 9211, R-7, R-11, R-8

When it is established that the file is to be rejected, prepare a letter of explanation to the Insured advising him of the Company's position. This letter should follow the guides presented in the Sample Letters Manual MU6885 and Benefits Release R-7 and Benefits Release R-11.

1. Prepare all correspondence of rejections in original and two copies. Send original to Insured; retain one copy in Field Office file; forward other copy to the Home Office with the benefits file.

2. If an assignment is in file, notify assignee of our inability to honor the assignment.

3. *Quote all grounds for rejection in correspondence*—the primary reason followed by the secondary reason(s).

4. Indicate Rejection Code Number(s) on MU112. Refer to MU164 for code numbers.

MU164

5. On Home Office copy of rejection letter, add as footnotes:

5.1 Diagnosis of condition which is the cause of the loss suffered.

5.2 Dates of onset of hospitalization or disability.

5.3 Reason(s) for rejection—include any additional information which influenced the denial of benefits.

RESCISSION HANDLING, 9212, A-14

If the application is attached to and a part of the policy, and a rescission appears in order, request a photo of the application from the Home Office, if not already furnished. Use the Memo to Home Office MU2206 for this purpose.

Upon receipt, analyze the application to determine whether misrepresentation exists. If you determine that there is sufficient justification for a rescission . . .

1. Obtain the benefits manager's approval and furnish file to field adjustor via the File Recommended for Personal Handling MU5618.

NOTE: Handle a rescission by mail only when there is no other means of timely personal contact available.

TIME LIMIT ON CERTAIN DEFENSES PROVISION 9213

2. Determine the amount of premium paid on the policy since its issue date, deducting all benefits paid on that policy.

RIDER IN LIEU OF RESCISSION 9216, R-20 AND PREEXISTING SICKNESS OR INJURY
RIDER FORM 2805M 9217

If the Insured is a desirable risk except for the condition that is the basis for the rescission, consider a rider in lieu of rescission as a means of conserving otherwise good business. At this point brief mention must also be made of the Preexisting Sickness or Injury Rider Form 2805M. Through the use of Rider Form 2805M and a rate-up in premiums, we are able to provide a means of writing impaired risks on standard income protection, hospital, major medical and major hospital contracts with coverage for preexisting conditions on a nonrescindable basis (except for nondisclosure of uninsurable conditions and fraud).

Basically the intent of this rider is to provide the Insured with:

DISCLOSED IMPAIRMENT 9218

1. *Full Coverage*, at a rateup in premium, for a preexisting sickness or injury or related condition which is *disclosed* on the application, provided:

1.1 The condition is not excluded from coverage, such as elective surgery.

1.2 Loss from any preexisting sickness or injury or related condition begins after the policy has been in force at least 12 months after the policy date.

UNDISCLOSED IMPAIRMENT 9219

2. *Partial Coverage* if a preexisting sickness or injury is *not disclosed* on the application and the Company is informed of such sickness or injury during the

first two years following the policy date, or if such sickness or injury results in loss which begins during this two-year period . . .

2.1 The policy will continue in force,

2.2 Benefits will be payable (as specified below), and

2.3 The policy will be amended,

subject to whatever limitations or exclusions should have applied under the Company's underwriting standards in effect on the policy date. Benefits, if payable, are payable for losses from all causes in such proportion as the premium bears to the premium that should have been paid in accordance with such underwriting standards.

CONFIRMATION OF BENEFITS RIDER FORM 2842M AND 9220

Confirmation of Benefits Adjustment Rider Form 2842M Rev. should be used in conjunction with Rider Form 2805M when it is necessary to adjust coverage after the issue date because of the disclosure of a preexisting condition not named on the application.

NOTE: Refer to the underwriting policy kits on the 2805M Rider Form and the 2842M Rev. Rider Form for specifics.

MUTUAL OF OMAHA,
Omaha, Nebr., May 23, 1972.

HON. PHILIP A. HART,

Chairman, Senate Antitrust and Monopoly Subcommittee, Room 104, Senate Annex, Washington, D.C.

(Attn.: Mr. Dean Sharp).

GENTLEMEN: This letter and the enclosed data for completion of your original questionnaire are sent in response to your May 18, 1972, letter, which was received yesterday. As mentioned in my April 24 letter, we very much appreciate the extension of time granted for the submission of these two remaining items.

You will note that the information in this letter is not subdivided according to category of policy coverage. We are unable to categorize in the manner suggested, primarily for two reasons. First, a portion of the individual business is special-risk type business on which the Company has not retained the kind of records needed to reflect in the information requested. Such records on these particular policies, as a regular practice, are not retained for the year for which the Triennial Convention Examinations have been completed, and such examinations have been completed for the years 1968, 1969 and 1970.

Secondly, with respect to our regular individual and family policies (other than special risk), the separation of claims actions by category of policy coverage is not possible because we maintain claims records on the basis of "claim audits", which will be explained subsequently in this letter.

It is important, too, to note that categorizing by policy coverage could be misleading, even as applied to the number of policies in force. Our codes are keyed to the kind of benefits provided in the basic policy, but the Company offers a large variety of benefit riders for addition to the basic policies. As a result, for example, many loss of time policies are issued with hospital-surgical benefit riders included; and many hospital policies are issued with benefit riders so broad as to in fact provide major medical coverage.

The following information, then, is our best estimate of the yearly totals of the various items requested.

1. Number of individual policies in force as of December 31

As indicated in the Company's annual statements, there were 3,252,697 such policies in force at the end of 1968; 3,248,986 at the end of 1969; and 3,171,289 at the end of 1970.

It must be recognized in evaluating these figures, or any claims figures which might be related to them, that the number of persons covered is several millions more than the number of policies. Perhaps 8,000,000 persons are covered under the Company's policies exclusive of true group policies. Precise counts of persons covered on any given day are not available. In the special risk area one policy might cover hundreds or thousands of persons and, of course, in the regular area there might be any number of family dependents on an individual insured's policy.

2. *Number of individual policies rescinded*

Rescissions result from the insured's failure to have given all information requested in the application for insurance. Recognizing that such failure can be a simple oversight, the Company sends a "reverification letter" and another copy of the completed application to each insured within two weeks after the policy is issued. It is hoped that the letter will serve to avoid future misunderstanding and disappointment. An excerpt from the letter follows:

"... Your policy has been issued relying upon the information contained in your application. A photocopy is attached and is made a part of the policy.

It is very important to you—and to us—that your application contains complete and accurate information. Enclosed is a photocopy of your application and we ask that you review it carefully and if incomplete in any respect provide us with any additional information. Factual and well-defined answers to all of the questions now will prevent misunderstandings at a later date.

Please complete and sign the appropriate spaces provided below, and return to us in the enclosed envelope. It is not necessary to return the photo. We sincerely appreciate the confidence you have expressed in our company and the courtesies you extended to our representative . . ."

Despite this and other efforts, rescissions do occur. We estimate that the number of policies rescinded by claim action was 4,635 in 1968; 4,883 in 1969; and 5,581 in 1970. It is not to be concluded, however, that the number of policies rescinded is identical to the number of claims which result in rescission action. One claim, in other words, can result in rescission of two or more policies.

3. *Number of individual policies reformed*

In this regard, too, we emphasize that the number of policies reformed is not identical to the number of claims which result in reformations, because one claim can result in multiple reformations. The number of individual policies reformed by claims action was 3,384 in 1968; 3,449 in 1969; and 1,591 in 1970.

4. *Number of individual policy claims received and number of claims paid*

In the consideration of this matter it is essential that there be a common understanding of terminology. What is a claim? What is a paid claim? Some persons or some companies might consider each claim draft to be a claim paid. Others might consider separate periods of hospital confinement to be causes of separate claims. Different kinds of loss (loss of income, expense for hospital services, expense for the services of a physician) might be considered different claims. We are unaware of the Subcommittee's definitions of the terms and therefore believe it is in order to give a brief description of our procedures and terminology.

Mutual of Omaha assigns a file number promptly when it receives an oral or written communication giving an indication that a claim has been incurred. A significant number of these cases—we estimate 5%—prove not to be claims because they are withdrawn by the policyowner, voided because of duplication, etc. We must estimate in this instance because our records are maintained on the basis of "claim audits" rather than on the various dispositions of file numbers.

Another segment of the file numbers originally assigned prove to be cases in which the loss or amount of expense is not pertinent to the kind of policy issued. Cases such as these (for example, the policy provides benefits for hospital confinement or the expense of a visit to the doctor's office but the insured incurs neither) are not included.

Also, Mutual of Omaha uses the following procedures with respect to claims arising from the same or related conditions.

(a) Under major medical and major hospital policies, all expenses incurred during the benefit period (usually two years) are given consideration under only one file number—even though there may be multiple kinds or periods of expense.

(b) Under basic hospital policies, periods of hospital confinement separated by less than 30 days are given consideration under only one file number.

(c) Under loss of time policies, periods of loss of time separated by less than 15 days are given consideration under only one file number.

(d) Under multiple policies held by a single insured, the various losses are given consideration under only one file number.

As indicated previously, the records for our special risk business have not been retained. Our estimate of the number of claims received under all regular and special risk policies, exclusive of group policies, on the basis described, is 732,895 in 1968, 735,371 in 1969; and 728,561 in 1970.

The number of claims paid must be estimated, too, because of the unavailability of special risk records and our previously mentioned system of maintain-

ing records on regular business on the basis of "claim audits". By "claim audit" we mean one claim processed under one policy. If an insured submits a single claim under two policies, for example, the processing is considered two claim audits.

In arriving at the number of claims paid each year we have subtracted from the estimated number of claims received the estimated sum of the claims which resulted in rescissions, reformations or rejections in that year. This method is not precise, obviously, in that it does not allow for the fact that some claims paid in 1968 were received in 1967, some claims received in 1970 were not processed to completion until 1971, etc.; however, such discrepancies tend to offset each other when a three-year period is calculated on the same basis.

The estimated number of claims paid, exclusive of group claims, on the basis described, is 692,325 in 1968; 690,723 in 1969; and 682,680 in 1970.

5. Number of individual claims rejected

Here, again, the understanding of terminology is most significant. For example, Mutual of Omaha receives requests for benefits from persons not insured by us but insured by other companies. Certainly, our denial and explanation under such circumstances would not be considered a rejection.

There are other cases, as mentioned previously, which involve explanations and would not be considered claims or rejections under objective standards—such as the coverage being for hospital confinement or the expense of a visit to a doctor's office but the insured incurring neither.

Also, we caution against misinterpretation which could result if declinations are related to claims received or to policies in force. As we have indicated previously, the number of persons covered exceeds the number of policies in force by several millions, and our procedures for counting claims result in a conservatively stated total. A declination, obviously, applies to only one person regardless of the number of persons covered under the policy involved.

The estimated number of claims declined on the basis described is 33,832 in 1968; 36,715 in 1969; and 39,356 in 1970.

5.a. Three major reasons for such claim rejections

- (a) Policy not in force at the time loss began.
- (b) Condition excluded.
- (c) Specific policy exclusion.

6. Number of claims paid in full, per maximum allowable expenses.

The number of individual claims paid in full per maximum allowable expenses, based on the figures in our response to No. 4 reduced by the number of claims paid partially (compromise settlements) is 690,381 in 1968; 687,072 in 1969; and 679,208 in 1970.

7. Number of claims paid partially (compromise settlement) in contrast to maximum allowable expense

A compromise settlement is made for one of two reasons, a question of fact or a question of law. A compromise which results in partial payment implies, of course, that there is a question as to whether the Company has any liability at all in the case. The number of such claims was 1,944 in 1968; 3,651 in 1969; and 3,472 in 1970 (the special risk claims necessarily being estimated again).

Sincerely,

A. M. HANSEN,
Senior Executive Vice President.

Senator HART. You list in that manual the four basic methods of disposing of a claim. The first is payment in full—payment of the full benefits; the second, a compromise settlement; the third, rejection of request; and fourth, rescissions.

For the record, I wonder if you could provide us with the percentage of claims that have been disposed of in the last 2 or 3 years, some appropriate period, for each of those four methods.

Did I manage to make that request clear?

Mr. SKUTT. Is that included in the findings now?

Senator HART. I believe not.

Mr. SKUTT. Mr. Hansen might help us on that.

Mr. HANSEN. I believe that the majority of that information was included in a letter that I wrote to you to the attention of Mr. Sharp, about a week or 10 days ago.

Senator HART. Well, it hasn't caught up with me. If it is, good. We will advise you if the information has not been received, in which case we will keep the record open (See p. 1218.)

Mr. HANSEN. If those percentages have not been received, I will be glad to furnish you a copy.

Senator HART. Thank you. As we have done with other insurance companies, as laymen, we are always curious about these classifications that you develop, the surcharges based on the occupation of the applicant, the individual, the place of residence, and so on.

In your health and accident classifications, you have several categories: Preferred risks, selected preferred risks, standard risks, and select standard risks.

Could you briefly give us your philosophy and explanation of this?

CONFIDENTIAL

policy	<p>Even though the insured's statement "No" to the question on the application concerning diabetes was made honestly, it was still a misstatement because it was later determined that he did have _____.</p> <p style="text-align: right;"><i>Mutual of Omaha</i></p> <p style="text-align: right;">3-12</p>
greater	<p>You learned earlier in the course that the person who <u>applies</u> for this policy must submit a properly filled out _____ form to the Company.</p> <p style="text-align: right;">3-49</p>
<p>(1) Preferred or Standard</p> <p>(2) Standard or Preferred</p> <p>(3) Preferred</p> <p>(4) All other</p>	<p>Up to this point in your study, you have learned that Preferred risks are eligible for a (greater/lesser) amount of coverage than Standard risks. This is true with one exception; the Select Preferred and Select Standard male risks are eligible for the same amount of coverage. However, because of the more hazardous occupational classification, the Select Standard male risk pays a higher premium.</p> <p style="text-align: right;">3-86</p>
individual companies	<p>Now let's list the three sources of benefits to be considered in determining total benefits from all sources:</p> <ol style="list-style-type: none"> 1. Individual and group coverage carried with Mutual of Omaha and other companies. 2. Disability benefits under _____ insurance policies. 3. Benefits provided under _____ laws (except workmen's compensation and employer's liability). <p style="text-align: right;">3-123</p>
treatment	<p>Also, that these periods of time which must elapse _____ the date of the _____ treatment are called "<u>Deductible Periods</u>."</p> <p style="text-align: right;">3-160</p>

<p>hospital 65</p>	<p>The benefits for losses beginning before age ____ are payable when the insured incurs expense resulting from necessary hospital confinement caused by injuries or sickness. You have already learned that the term "injuries" means accidental bodily _____ received while the policy is ____ force.</p>
<p>disease confinement 30</p>	<p>This completes your study of benefits payable for hospital _____ beginning before age ____ . Now we are ready to begin a study of benefits payable for _____ confinement beginning on or <u>after</u> age 65.</p>
<p>in force</p>	<p>Each time the premium is paid, the policy is renewed. Since its payment results in renewal of the policy, this premium is called a _____ premium.</p>

(d) IMPORTANT: If nonselective underwriting is desired, indicate so on M21 or by note When APPS are submitted. Otherwise the group will be underwritten selectively.

7. IMPAIRED RISK MAXIMUM LIMITS

7.1 Unimpaired risks secure regular coverage. Impaired risks are issued limited coverage. An impaired risk is any risk requiring a rider or that is un-insurable in accordance with "Underwriting Appraisal of Physical Histories" manual. (If a group qualifies for "no selection," impaired risks may have the following plans without riders.)

7.1.1 Uninsurable Risk:

- 121DL-122DL: 13 weeks' sickness and accident—8th-day sickness—\$25.00 weekly benefit
- 121H/HF: 30-day plan—\$8.00 daily room and board
- \$150 hospital miscellaneous (2718M)
- \$225.00 surgery (2722M)

7.1.2 Riderable Risk:

121DL-122DL: 5-year accident, 1-year sickness—8th-day sickness—\$40.00 weekly benefit

121H/HF: 120-day plan—\$12.00 daily room and board

The first \$100.00 plus 75% of \$1,000.00 miscellaneous (2721M)
\$300.00 surgery (2723M)

\$150.00 medical (in hospital) (2727M)

7.1.3 The following "additional" benefits may be included *if everyone in the group applies for these benefits*. Medical Diagnosis and Home Care (2731M), Dental Care (2730M), Hospital Outpatient (2726M) and Specific Loss and Specific Injury Benefits (2732M).

7.1.4 The following "additional" benefits *may not be included unless cleared by Home Office*. (There may be a history of certain impairments which prohibit issuance of this coverage.) Dread Disease (2729M), Accidental Death and Dismemberment (2714M), Accidental Death (2713M) (2715M), Accident Expense (2728M).

NOTE: In qualified PRD and SCF groups with over 100 employees or members, all impaired risks are eligible, subject to the participation requirement for "riderable risks" limits shown above.

NOTE: If over half of the other people in the group have applied for less than the above limits, impaired risks will be issued the same limit as the others.

8. NONSELECTIVE ENROLLMENT PERIODS

8.1 PRD Groups. When the group qualifies for "no selection," a 30-day open enrollment period is allowed. After this period, all additions will be "selective" except new babies and new employees who apply within 60 days of the date of employment or a longer period if an employment qualification applies. (*Complete "date joined" question in the application.*)

8.2 SCF Groups. When the group qualifies for "no selection," a 30-day open enrollment period is allowed. *After this period, all additions except new babies will be "selective."* (Franchise Division approval and current roster must be obtained for future open enrollments.)

NOTE: When a nonselective group falls below the required participation requirement, all additions will be issued on a selective basis.

9 IN-FORCE GROUPS—121DL-122DL AND 121H/HF

If these groups qualify for "no selection" in accordance with the participation requirements, the Franchise Division must be notified to make the necessary changes.

10. BENEFITS CONSIDERATIONS—CODING MU112 "SELECTIVE" AND "NONSELECTIVE"

NOTE: You will recall that under the old forms, the 21DL (loss of time) policy had an origin provision covering "loss of time *beginning* while this policy is in force and resulting from: (1) accidental bodily injuries received while this policy is in force or (2) sickness contracted while this policy is in force." The old hospital forms 21H/HF *did not* have such origin except for injuries. Fortunately, all of the new Policy Forms 121DL-122DL and 121H/HF *do* contain an origin provision for sickness or accident.

It is important to be aware of the above-stated features of these plans so as to understand the effect of the "selective" and "nonselective" underwriting described in the following paragraphs.

10.1 "Selective" Underwriting. Where a group has been underwritten on a selective basis, the word "Selective" will appear in the rider or endorsement on the MU112. *These should be handled as any regular policy written on a selective basis.*

10.2 "Nonselective" Underwriting. When a group meets participation requirements (see Section 6), *riderable risks* or uninsurable risks are given *limited* plans and unimpaired risks have a choice of plan (see Section 7). In any one group three versions of 121DL-122DL or 121H/HF may be issued. *Benefits issued to the particular policyowner will be shown on the MU112.*

10.3 "Nonselection" Connotation. On these policies the underwriters, relying on the answers on the individual Insured's application, have the right to issue regular or limited plans (see Section 6) to the individual applicant or reject issuance

to the individual group if the percentage of unimpaired risks is above acceptable limits. *Known preexisting conditions material to the risk not shown on the application discovered during processing of a benefits request give the right of rescission of the individual policy.*

NOTE: If a *preexisting condition is shown on an application* and the policy is underwritten on a "nonselective" basis, benefits *will be allowed* for the condition.

10.4 Coding. The following coding will be used on MU112:

10.4.1 If the application shows *no impairments*, the MU112 will show . . .

"No selection—No impairments on app"

14.4.2 If the application shows impairments, the MU112 will show . . .

"No selection—No impairments on app"

Holmes Bureau coding for the impairment, thus: "No selection—John—1318 shown on app."

If there is more than one Insured with impairment, the name of each and the impairment code will be shown.

11. BENEFIT CONSIDERATIONS

11.1 Rescissions. It is the responsibility of all benefits personnel to safeguard the conservation of these groups which have cost our Company considerable time and money to establish.

In recent years a few Franchise groups involving many members have been nonrenewed because of rescission action on one or more members in each group. The groups were lost, not because of the rescissions, but because of a lack of proper communication between the Company and the groups with poor public relations resulting.

In order to improve this situation, the following guides are established if adverse health history is established and it is necessary to take rescission action on a member of a Franchise group.

11.1.1 If the policy has been underwritten on a *nonselective* basis, return the file to the Home Office. No final action is to be taken until it has been reviewed by the Franchise Division and Benefits Service Administration.

11.1.2 It will not be necessary to return the file to the Home Office if the policy has been underwritten on a *selective* basis.

11.1.3 After it has definitely been decided that rescission action is to be taken, discuss the file with the general basis with the Insured.

If the field adjuster and benefits manager are satisfied that the rescission is acceptable with no apparent future repercussions, no further action should be necessary. If in the opinion of the field adjuster or the manager such rescission will cause any future complaints, the benefits manager should call on the manager of the particular Franchise group to explain our handling. Whenever possible, especially with large or new groups, the benefits manager should be accompanied by the general agent.

Such handling will cement good public relations and not only help conserve business but help project the proper image for potential group sales.

MR. SKUTT. Yes, I can give you what I understand to be the philosophy of our organization. Mr. Hansen might respond with some examples.

Senator, going back to the earlier days of our organization, and I have been with it for quite a while now, we have had an objective of bringing protection to all people, regardless of occupation.

There was a time when companies, many of them, specialized in professional, or so-called preferred risk. But one of the things that has marked our progress, and is partially responsible for it, I think, is the fact that we broadened the base of our clientele and our coverage.

We were offering coverages years ago to people in industrial, and other walks of life, that normally at that time were not qualified for this type of coverage.

We have endeavored to carry out that program in all types of our protection. There is, of course, to be remembered that there is a distinction in writing a loss of income policy, and in writing a hospital policy because you have a different type of liability involved. To be entitled

to a loss of income policy, one should be productive when they are insured.

Now, a hospital policy is different, and can be issued to people who do not have any earned income.

So there are those distinctions to be made. But perhaps Mr. Hansen, who has lived with this for a long time himself, and is in charge of our product and services that I mentioned earlier, could expand on that.

Mr. HANSEN. Thank you. Senator, Mr. Skutt has clearly identified the situation and I want to emphasize it. I want to distinguish, first of all, between the hospital-medical coverage, which, I believe, is referred to here as health care coverage, as distinguished from loss of time coverage.

Now, the occupational classifications to which you have referred applies to loss of time coverage for occupational variances effect. It does not apply to the health care coverage, where in the underwriting of health care, we make it available without regard to occupational classification.

Senator HART. Well, then if I find in your underwriting guide differing treatment for an undertaker and a manual laborer, I am to understand that those are classifications that are applicable to loss of income protection, but not to health and hospitalization?

Mr. HANSEN. Your understanding is correct, sir.

Senator HART. Not that world survival hinges on the answers we get, but just because we are curious—I notice in this occupational data manual that you give a different rating to an undertaker who embalms, and one who does not embalm.

Now, what is the theory for that?

Mr. HANSEN. I will give you the theory as I understand it coming from our medical directors.

Incidentally, you will be interested in knowing that the late Dr. Mayo has collaborated with us on these manuals, and has helped me in the preparation of the material.

The man who does no embalming is not subjected to the disease condition of the patient who the other man may be working upon. He is not subjected to the cutting of his hands, or the involvement with the embalming fluid, and this sort of thing.

Therefore, there is a different accident and health risk involved when a man is embalming than when he is doing office work only in an undertaking establishment.

Senator HART. I would not quarrel with that answer, or Dr. Mayo's theory there.

Mr. HANSEN. And I am like you. I sincerely hope the world doesn't hinge on that answer.

Senator HRUSKA. Mr. Skutt, I am not surprised, but I am gratified at the fashion in which you have treated the problems of demands for standardization. I presume that means standardization of benefits, standardization of premiums.

Mr. SKUTT. Yes.

Senator HRUSKA. And so on. There is an inconsistency if we require standardization by law, for example, and place a floor on the ceiling. We remove an element that is very precious to the Subcommittee on Antitrust and Monopoly, and that is that business of competition.

Mr. SKUTT. Yes.

Senator HRUSKA. And we encounter it in other fields which we have gone into. There are some people who say that gasoline is gasoline, and ethyl gasoline is ethyl gasoline and, therefore, the advertising of gasoline that will start your car faster, and that it will start it better, in cold weather, and so on—that is all poppycock.

Now, I am wondering what has been the impact of the uniform policy provisions law—as I understand—all States have it now?

Mr. SKUTT. Yes.

Senator HRUSKA. What has the effect of that law been upon this general area?

Mr. SKUTT. I am glad that you inquired into that because it is one of the things that I did not cover in the oral statement here that was included in the formal report to which you referred.

We already have pointed out the obvious to us, undesirability of standardization which would eliminate innovation and additional coverage, and so forth. But the fact remains that the National Association of Insurance Commissioners long ago sponsored the uniform provisions law to which you referred.

Fortunately, that is placed as a base and not as a maximum. So, in the regulatory requirements outlined in that law, all companies are required to meet the minimum. But it does not establish such standardization or straitjacketing that you cannot—if you do as we do at Mutual of Omaha—offer more than the minimum requirement.

Senator HRUSKA. That would seem to apply to all lines of merchandise.

Mr. SKUTT. I certainly hope so.

Senator HRUSKA. Certainly there are things that should be packed into any product that is on the public market by the way of minimums, and then anything that is furnished over and above that is legitimate and is to be encouraged if we are going to make any progress at all.

Mr. SKUTT. Right.

Senator HRUSKA. Now, one of the things that we can conquer immediately when we think in terms of Federal legislation is this idea of the variance of coverages and the amounts that are acceptable or are practical in different geographic areas. Can you give us some examples of that?

Mr. SKUTT. Well, of course the underwriting experience with a company varies by locality, and then their coverages are supposed to take into consideration the experience in the various areas and modify their underwriting practices, or the policies they offer, accordingly.

However, I think on the whole, Senator, you will find that that is not defined as greatly as it could be in a way because it is rather difficult to determine the precise percentage of difference in the experience in the one area, vis-a-vis another, if that is what you had in mind.

I think it is kind of like the automobile writers, perhaps, do in having a State where they have a higher loss ratio, a higher rate of accidents, and a higher expense for repair, that enters into the overall cost.

Now there could be more progress made in this zoning field, in my opinion, than there is now. I'm talking now of health insurance. This probably could be improved upon because the general policy is to try to make coverages available all over the country.

For instance, in our case, we have coverages in all States of the Union, while the underwriting department, as Mr. Hansen could advise, gets into various coverages by section depending on underwriting experience. We try to give the maximum benefits at minimum cost to all areas.

Senator HRUSKA. Of course we have some Federal regulations in many ways.

Mr. SKUTT. Yes, indeed.

Senator HRUSKA. For example, every once in a while, Congress increases the minimum wage.

Mr. SKUTT. That is right.

Senator HRUSKA. Does that have an impact on your business?

Mr. SKUTT. Of course it does. The minimum wage, the increase in social security tax benefits, the employer regulations, the Federal employment practices, all of those things involve extra responsibilities, extra functions, extra expenses, and we are glad to shoulder them.

I think that they are important and I think that they are necessary, but they do end up as part of your overall operating expense.

Senator HRUSKA. There are other ways, and of course some of those are covered in your statement. Other testimony that we have had has gone into the same thing.

That is all I would have at the present time, Mr. Chairman.

Senator HART. Mr. Sharp?

Mr. SHARP. Thank you, Mr. Chairman.

Senator HART. I beg your pardon, Mr. Skutt. We have been joined by the Senator from Florida.

Senator GURNEY. I crept in when you were looking the other way.

First of all, Mr. Skutt, I want to congratulate you on this very comprehensive statement. I am sure it will help the business of the subcommittee.

Just two or three general questions. The chairman touched on this when he was questioning, and that was this business of insuring of high risks. Let me ask you this question: Do you exclude some categories from your health insurance coverage completely?

Mr. SKUTT. Well, earlier, Senator, we tried to differentiate between our hospital coverage and our loss of time coverages.

Senator GURNEY. I am talking about hospitals.

Mr. SKUTT. Mr. Hansen here, who is our executive vice president in charge of underwriting and product and services, will be able to answer that more clearly than I.

Mr. HANSEN. Senator, I would answer your question in this respect. Our effort is to try and insure as many people as possible. We would like very much to be able to insure everyone that applies. However, unfortunately, a few people along the way wait until they are already sick or hurt. They wait for 50 years without an insurance plan of any kind, and then they get sick or they get hurt, and then they seek to purchase insurance.

Then it is as Mr. Skutt distinguished earlier. It is no longer insurance. It becomes a matter of, "Let me give you a few dollars, and you pick up my bills."

Now, these people who wait until they are under medical management, and have problems, are sort of like the fellow who has a great roaring fire going in his house, and he calls the fire department, and

then he says, "Where can I find some insurance to cover my fire loss?"

There are a few that cannot now be insured because they did not avail themselves of the opportunities along the way.

Senator GURNEY. I would certainly understand that, and obviously, most of us would understand that it would not be fair to insure those people to the detriment of the rest of your customers.

But that really wasn't my question. My question was are there certain categories of people in certain lines of work that you do not insure, or—

Mr. HANSEN. We take people regardless of occupation on our health care. Now, this is our hospital-medical.

Senator GURNEY. Yes.

Mr. HANSEN. Regardless of occupation.

Senator GURNEY. And that is true of individual contracts as well as—

Mr. HANSEN. I am speaking of individual contracts.

Senator GURNEY (continuing). As well as group policies?

Mr. HANSEN. That's right.

Senator GURNEY. Some insurance companies don't—

Mr. HANSEN. We do not refuse anyone in hospital-medical field because of occupational endeavors.

Senator GURNEY. The other question I wanted to ask is—it deals with this whole area of cost control, and I know that you have got a good statement here. I glanced through it, but I didn't read it completely.

I suppose if these hearings have developed any one factor, that is the thing that troubles us more than anything else. I am sure it troubles you even more than us because it is your business.

What I am asking is, are there any other suggestions as to what can be done to better get on top of cost control, perhaps as far as the Government is concerned as well as yourself?

Mr. SKUTT. Well, Senator, I guess one of the first things we have to do is have health care more accessible. I think that undoubtedly has entered into its expense.

I am talking about the availability of doctors, for example. It is difficult to get a doctor in parts of the country, and then when you do, naturally, the doctor charges proportionately sometimes to the difficulty that he had in locating or traveling to the patient.

Now, I don't say this with any disrespect to the medical profession at all, because God knows that we would have a sad situation in this country were it not for the great progress of the medical profession.

But to answer your question, we are going to have to have more people purveying health care. The old rule of supply and demand gets in here, and I think that is one of the problems of the medicare program. It increased the demand, and there was no contemporaneous action to increase the supply of doctors and of nurses, of hospitals and nursing homes, and so forth.

Then I think there is the question of overutilization—I don't think we can blame the doctors alone about so many people receiving medical care and about overutilization contributing to the cost.

I saw a cartoon the other day of a little old lady sitting in a doctor's reception room, and she was saying to the receptionist, "Well, if doctor

doesn't want to see me any more, what am I going to do with my Tuesdays and Thursdays?"

Well, if you have a combination of circumstances, excessive demand for their services and scarcity of those providing it. I think that you have to start there.

From then on, I think you get into other areas of responsibility. Earlier, before you came, I believe, we put this little diagram up here. It was done hurriedly, but it represents what we feel is a logical answer to making some more substantial progress in this field. That is the interdependence of the services by the Government, financing programs of the Government, the financing by health insurance institutions, the Blue Cross service organizations, benefit societies, and so forth, and the purveyors of health care.

If I may take a moment—I guess you weren't here, were you——

Senator GURNEY. No, I did hear——

Mr. SKUTT. We feel if we can beef up the dedication and the performance of all, that we can make a great deal of progress.

I think there is a foundation laid now, thanks partly to the inquiry that is being made, the needling that Senator Hart referred to earlier, and so forth, I think this is making us all more interested in doing a better job.

Senator GURNEY. The financing aspect, I think blows up and aggravates the abuses?

Mr. SKUTT. Yes.

Senator GURNEY. I think that has been true in part with medicare. Overutilization, and just plain overcharging, sometimes, and just plain very wasteful management.

How are we going to get on top with that? What is the role of private insurance companies like yours and the Government in order to get on top of that?

Mr. SKUTT. Well, I think the health maintenance organizations is a new development and offers great possibilities. We are identified with some 12 of them now around the country.

We have helped save the medical college at Omaha, one of the medical colleges, Creighton University, by raising a considerable sum, as I think the Senator knows, to keep it open.

And this private medical college was about to close I think these programs and making more people available, getting more nurses and people in the medical profession, will do a lot to beat this problem, Senator.

Senator GURNEY. I've discussed this problem of shortage of doctors with one or two doctors. Have you any ideas on how to resolve that one? I think you're right. I think there is a shortage of doctors.

Only last week, while I was down in Florida, a friend of mine was telling me about a friend of his who was taken to the emergency room of a hospital, and the doctor didn't show up for 6 hours.

And my friend said, "I thought of going out and cashing in some chips with a doctor friend of mine, but I was afraid to do that for fear he might not show up when I needed him.

So, I mean, this is a real problem.

Mr. SKUTT. Well, you put your finger on it right there, and I think one of the oversights that's been made in the approach to this whole problem by government and by insurance institutions to a certain ex-

tent, is the assumption that if you have enough money available, you're going to get proper medical care. Well, that's not the whole answer. This man you spoke of was well qualified, probably, to pay a reasonable doctor's bill, but you just can't get them if there are not enough of them. And I think that was the No. 1 problem, rather than the second problem.

I think that was something we should have been doing earlier instead of increasing the demand for them, by providing more money for health care.

Senator GURNEY. Have you or any people in your company discussed this with medical school deans or faculty?

Mr. SKUTT. Indeed we have, and there's a part of the exhibit filed with our formal statement here. It's the latest report on the Creighton Medical College, where they are reducing their curriculum, trying to turn out doctors faster.

And we think that should be implemented around the country as much as possible, not with the idea of diminishing the dignity or ability of doctors, but as an answer to the practical problem of getting more doctors in the field.

And I think the AMA has endorsed it to some extent, a reduced curriculum. I am told that, unverified.

Senator GURNEY. Have you found that this is the general trend among other schools, or just in a small few isolated cases?

Mr. SKUTT. I can't answer that, Senator. I'm not aware of the practice in the other colleges. I think I've heard, you know, discussions at this particular medical college, that it was being looked at by many other schools. How much implementation has taken place, I cannot say.

Senator GURNEY. You know, curiously enough, I think the only reason why Florida has been able to keep abreast of this doctor problem, and we, perhaps, have the most difficult one in the country at the moment, was by Mr. Fidel Castro, down in Cuba.

Mr. SKUTT. Yes.

Senator GURNEY. Actually, almost to the man, at the University of Havana Medical School, and most of them in this country and most of them in Florida came to us, too, and are working in Florida hospitals and practicing medicine.

Had it not been for this, I don't think we would have ever come abreast of our problem.

Mr. SKUTT. May I ask a question? When the doctors are from Cuba, do they have to pass an examination in Florida before they're admitted to the practice?

Senator GURNEY. Well, they do, although the hospitals have let them serve in some intern capacity until they have done that. That's not totally satisfactory, but it is policy.

What do you think Government can do to speed up this process?

Mr. SKUTT. Well, I think the Government, in addition to these loans that can be made to these medical institutions, medical colleges, and so forth, can continue to show interest in their curriculum, and not with the idea of controlling medicine at all.

I think the individual opportunity of doctors to do research and to handle their patients and so forth is a rather sacred relationship and should be preserved.

But on the other hand, I think the Government should follow through as much as possible in making sure that there is prompt help to these institutions when needed. They should make sure they're using it properly and paying some attention to getting more doctors to the field to help patients, and not just going into research or administration.

Senator GURNEY. One final question about this school business and cost control, and the improvement of medical services with more personnel. I think I'm less impressed with Government bureaucracy the longer I have any connection or acquaintance with it—the Government. It is necessary sometimes, but sometimes it's a necessary evil. But, on the other hand, there is a gap and, of course, we have to fill it.

And we have to have a way of doing that because we have to provide health for the care of people. But, again, I go back to the general question that I think insurance companies like your own, who play a very important factor in this, and I agree with them and defend that—that's the best way. A partnership between private companies and the Government.

But I must say I would feel a lot better if there was a lot more surveillance and better surveillance on the part of the private companies in the area of cost control and in the area of implementing the number of people we have in the health business, because I honestly think if you put your resources and talents to that, you'd do a better job than we do.

Mr. SKUTT. Well, sir, we do have a responsibility there, and we've tried to manifest interest in it, particularly in recent years.

Mr. Hanson may know of some instances or examples that would be of interest to you to show you what we are trying to do.

Senator GURNEY. I don't want to take up the time for—it was more of an observation than anything else.

I do believe in the partnership, and I think it does——

Mr. SKUTT. Let me say that I think one of the things we ought to do, as part of this interdependent responsibility, is to try to appreciate the problem of the doctor, too, on a time factor.

Now, there was a time, you know, when company reports required so much time; they had to fill out complicated blanks and all that sort of thing, and in our efforts to try to cooperate with the medical profession and try to make it easier to them, we have a direct line from our office all over the United States.

I mean, we accept collect calls from anywhere, day or night; it's a 24-hour service. A doctor can pick up this telephone and in Miami or in Detroit or anywhere else and telephone our number and there's a recording right there; there is someone there looking after it, and he can dictate the report on this patient right there. He can do it at the best time for himself and at any time for us.

We are there all the time. Now, we must recognize that doctors have a tremendous demand on their time, and one of the problems contributing to that is so much bookwork and that sort of thing, paperwork, but we are trying to make it easier for them. I think this has been given widespread publicity among the medical profession itself. Of course, when we get back, since you brought this up, we will look at it again, because the facilities, have been functioning for about how long?

Mr. HANSEN. About 3 years.

Mr. SKUTT. About 3 years, and it is real interesting—sometime, Senator, you might want to look at it, because I think it will help a lot in freeing more time for the doctors to treat the patients, rather than to fill out reports and so forth, and to expedite the attention that we give the claims, too.

That is one of the reasons we have it.

Senator GURNEY. The usual problem of paperwork, is what you are saying?

Mr. SKUTT. Surely.

Senator GURNEY. Thank you, Mr. Skutt.

Senator HART. Mr. Sharp?

Mr. SHARP. Thank you, Senator.

Mr. Skutt, Mr. Hansen, we appreciate—I personally appreciate the cooperation that you have given to this staff on the study by the subcommittee on health insurance.

Mr. Skutt, in part of the material that was furnished to the subcommittee, there was a letter from one W. M. Moss, vice president and chief underwriter of your company—

Mr. SKUTT. Yes.

Mr. SHARP (continuing). To policyholders that indicated that premiums would have to be substantially increased because of the inflationary trends. This letter indicates that, because of the substantial increase in premiums, the policyholder may want to accept a new policy design as a substitute for the same premium as the old one.

Now, obviously, this new policy particularly, affords less coverage than the old. I am not being critical because we can understand that your company must charge a premium high enough to cover expenses and claims.

However, I wonder if you think, yourself, it is a good idea giving less coverage to the consumer in face of the inflationary trends which the letter speaks of.

Mr. SKUTT. Subject to further comment Mr. Hansen may wish to add, I'd like to tell you, Mr. Sharp, what our philosophy is. We feel that if it becomes necessary, because of excessive losses, to take some action with respect to either increasing premiums or modifying the coverage, where possible, we shall give the insured the choice if we can, but we must offer him a specific program.

And I think that the instance to which you referred, the communication is one designed to make sure that the insured maintains some kind of coverage if he or she desires it.

Mr. Hansen may wish to supplement that answer.

Mr. HANSEN. I have nothing to add.

Mr. SHARP. Along the same line, a memorandum contained in a group division claim manual which your company furnished to the subcommittee concerning the conversion privilege—the privilege that one has to convert from a group employer policy when he leaves the company to an individual policy.

It is indicated that the maximum room and board which should be written under the conversion policy, would be \$25 a day, whereas the group policy provided for the per diem to be a semiprivate room which we understand could be more than \$50 a day in benefits.

Now, how realistic is this type of coverage when the average daily hospital room rate is close to \$100 today?

Mr. SKUTT. Well, of course, the objective should be to try to meet the cost of care even though it rises in such high percentage. The program that you talk about is a conversion program that we have for those whose group insurance terminated, if I understand correctly, because they have left the employer or retired, or for some other reason.

Mr. SHARP. That is right, sir.

Mr. SKUTT. And we then have to operate on the sort of coverage that can be offered on a prudent basis for their new category or classification. We would hope that we would be able to offer them as much as possible to help meet costs, and I do believe. Counselor, that we offer some more than \$25 a day. I'm not sure. Mr. Hansen could verify that.

Mr. HANSEN. We certainly do offer more than \$25 a day. Any man coming off of a group program has an option of buying any package of insurance that we have marketed.

Let me ask Mr. Sharp if I understood his question correctly.

Mr. SHARP, you said, "How realistic is it to offer a lower bracket at average cost or about \$100 a day?"

Mr. SHARP. No, sir, no, sir. What I am getting at is the maximum room-and-board benefit which can be written under the conversion policy is \$25 a day, and the average daily hospital room rate, according to the American Hospital Association last year, was \$97.

Mr. HANSEN. Mr. Sharp, somewhere, your figures and mine don't agree.

Mr. SHARP. The \$97 which is average rate per diem per patient for inpatient hospital care.

Mr. HANSEN. Now, we are together, but there is a difference between the daily board and room allowance under the policy and the average per diem amount paid under the same policy. For example, that policy which you are talking about, and I am not familiar with the particular item, could very well provide for another \$50 a day in miscellaneous charges so that the average per diem payment under the policy, comparing it to the figures that you used on the other and could well be \$100.

Mr. SHARP. To clear this up, this is taken out of "Group Division Claim Manual Audit, Group Conversation, May 1970," page 1. I am quoting. "Please refer to the attached underwriting rules and rates applicable for both Mutual and United"—I take it United is a subsidiary. "At this time, the maximum room and board benefit which can be written is \$25."

Mr. HANSEN. That is under the conversion privileges, but again, a man could buy, if he wanted to, he could buy anything else that we offer.

Mr. SHARP. If he is insurable. What if he is not insurable? What if he has a medical impairment?

Mr. HANSEN. If he is not insurable, he is guaranteed the \$25 a day board and room.

Mr. SHARP. Senator Hart received a letter from a person in Ohio. This is not, concerning your company, but just to get at the general problem here. In this letter, this person states:

Several years past, I had a coronary where considerable expense was taken care of through the insurance policy of the corporation where I was employed. I recently retired and no longer have the full benefits of a corporate program as when I was actively employed and further had to pay approximately \$600 for a medical policy whose benefits were far less than that which I had enjoyed while actively employed. This, too, does not seem equitable but is somewhat beyond the point.

And then he goes into the problem of not being able to collect from this particular company.

But in another letter received from a person in Arkansas, May 26, this person says, "I worked for 8 years before I became ill." She has lymphosarcoma, which is a form of cancer, and had a group policy which she says she had to use to pay for it, but when she had to convert it to an individual policy, "they sent me a little surgical policy not worth anything to me at all. Things were cut to practically nothing. And I would have to be a surgical patient for it to pay even that. Of course, no other company will insure me and" * * * "X company * * * "knows a surgical policy is no good to a person with lymphosarcoma."

"I wrote to them and told them I thought I should have the same type policy as I had before I became ill, but it didn't do any good."

Do you have any comment on the person retiring or being ill and leaving that company who has had good group coverage benefits and now has to pay \$600 a year or more?

Mr. SKUTT. Mr. Sharp, I think the insurance institutions will be happy if the employer's program continued the benefits after retirement if they can persuade them to do that—that could get into cost factors on premiums paid by the employer. I do think that that would be a desirable objective, and I believe that some of them are trying to bring up their group programs to do that and I am sure the insurance institution will be happy to cooperate.

Mr. SHARP. We heard testimony yesterday, Mr. Skutt, from a company that indicted that the coordination of benefits plans, of the large group companies excluded his company from the marketplace. And in one of your submissions on the subject of coordination of benefits, it is indicated that the reasoning behind this is that people should not make a profit because of sickness or accident.

Now, the thing we are wondering about is whether or not in your coordination of benefits plan you permit coordination in such a manner as to allow payment of 100 percent of the expenses incurred by the policyholder for an illness or accident, or does the consumer end up with two or more policies still having to pay out of his own pocket for the expenses incurred?

Mr. SKUTT. That is specifically a question for Mr. Hansen because that is in his field of supervision.

Mr. HANSEN. We sure can get into some knotty problems sometimes in connection with coordination of benefits because you get into questions such as who is the primary carrier and who is the secondary and this sort of thing.

However, let me comment this way: Assuming that both programs were going—would go together to constitute one reasonably sized program in the very beginning, I would say that the purpose of coordination of benefits clause is not to put the policy owner in a position where he must spend out of pocket.

The purpose of the coordination clause is being today is to prevent people from going to the hospital, staying there for unreasonably long periods of time, utilizing facilities that are not necessary simply because they are making a profit and taking money home in their pocket by overutilization.

The purpose of the clause, then, as far as I am concerned is to prevent that, and certainly it is not designed at or aimed at making the policyowner pay out of pocket. Now, it might happen if both policies were very small policies.

Mr. SHARP. As I understand the concept, I think—please correct me—you have a concept in the health insurance business called the “allowable expense,” and what constitutes allowable expense. And most policies contain an 80-percent co-insurance clause, meaning that 20 percent of the expenses are going to be picked up by the patient. Is that true, basically?

Mr. HANSEN. Yes, patient.

Mr. SHARP. Yes, sir; and some policies have deductibles. Is that true?

Mr. HANSEN. Yes.

Mr. SHARP. Some have waiting periods, 1, 2, 3 days; is that true?

Mr. HANSEN. Yes.

Mr. SHARP. Now, doesn't this place a burden on the patient? I think there is much overutilization of the most expensive facility, the hospital, but isn't there being placed by those co-insurance provisions, deductibles, waiting periods, a burden on the patient? He has to bear some of this.

Mr. HANSEN. I don't believe it poses any particular burden to him. And in most instances, as it relates to some of the things we are talking about, the customer makes his choice, deductible. We offer—

Mr. SHARP. I didn't hear you.

Mr. HANSEN. I say, in some instances, the customer makes the choice. For example, we offer policies that have no deductible. We offer policies that have \$50, \$100, and \$150 deductibles, and these all serve to bring the price of the coverage down. Now, if the man decides that he only wants to spend so much money, he may decide to use a deductible.

Mr. SHARP. In group insurance policies, the individual, the employees, of course, that (a deductible) is subject to the bargaining arrangement between the union and management. Is that true in a group policy, normally, the employer-employee relationship—

Mr. HANSEN. I suppose, basically.

Mr. SHARP. And even in individual policies, in order to keep the so-called claim cost down, we had an insurance company here this week that stated that we need coinsurance and we need deductibles in order to keep the claim cost down, and to keep the premiums down, so that the buyer can afford the coverage. Is that basically the philosophy?

Mr. HANSEN. I would disagree with that and I think our company would disagree with that.

Mr. SHARP. Do you offer—

Mr. SKUTT. There are some cases where the insured might prefer to take care of his own liability for the first \$100 or \$300 or \$500 rather than pay the premium that that policy would require by not having the deductible, and if that would help him carry some coverage, which

he should have, by offering that sort of a program, I think it is desirable, counselor, to pay respect to his wishes.

MR. SHARP. Now, I am not quarreling with this. I am just trying to understand how the system works here. Let us assume I have a \$1,000 medical bill, and there is an 80 percent coinsurance clause. Because I want a major medical policy, let us say, and a comprehensive plan, the premiums of both together, according to information furnished by the insurance industry, could be as much as a thousand dollars a year. And perhaps I am earning \$9,000 a year like 60 percent of the American families, and maybe I cannot afford the \$1,000 premium, so I would want to opt for a coinsurance provision and perhaps a deductible helping me save the premium up front. I will worry about the out-of-pocket when the catastrophe strikes. Do you believe that we should be finding ways to help consumers, these patients, eliminate these financial, and other barriers that may be preventing them from seeking early and comprehensive medical treatment? Do you feel that way, Mr. Skutt?

MR. SKUTT. I certainly do and I think that is what this is all about. And I think we are making progress, and if we can get these costs under control, that is going to take care of a good share of the problem in the premium because that is what is entering into the premium—the risk involved, and when you have these excessive or inflated costs for medical care, you are going to have to charge more per premium. So I agree with you, sir.

MR. SHARP. So based on your coverages, for examples, and again. I am not quarreling, out of a dollar, let us say, I guess you would pay back about 70 cents in benefits, which is rather good compared to quite a number of other individual companies?

MR. SKUTT. Yes.

MR. SHARP. So I would like to just see here, with this point, do you feel it is the doctor or the patient who controls the utilization of medical facilities in this country and their costs? What is your general feeling on this? Do you think it is you or I, as a patient, or the doctor?

MR. SKUTT. The patient or——

MR. SHARP. Yes; after the initial office visit.

MR. SKUTT. Well, I suppose both have something to do with it. The doctor fixes the charges and the patient pays them or tries to have them paid and is responsible for them so I don't know whether there is much room for negotiation on those things or not, but again, that gets back to the availability of medical care and the cost factors enter into it.

MR. SHARP. Is it not really the doctor, though, who decides whether the patient goes to the hospital, the most expensive treatment or receives less expensive treatment on an outpatient basis, if possible?

MR. SKUTT. I think for the most part, it is, and I pointed that out. I believe, in the statement earlier, that the doctor says when the patient goes to the hospital.

MR. SHARP. So you agree, then, that the doctor decides if a patient can be discharged, or goes to a nursing home, or an extended care facility, and it is the doctor who really selects the laboratory tests, and prescribes the drugs for the patient. You would go along with this?

MR. SKUTT. Well, I think you have covered quite a bit of territory there. I do believe that the patient might be able to persuade the doctor if he wanted to go home or go to a nursing home instead of staying in

an expensive hospital, and say, "Well, doctor, don't you think I've reached the point where I can go?" rather than waiting for the doctor to say it to him himself.

I mean, it is a joint decision. The final decision rests with the doctor, of course, because if he says, "No; you can't leave without imperiling your health," why, then, the patient will stay.

Mr. SHARP. Of course, if there were no extended care facilities available, or home care equivalent to the expensive in-patient hospital care, I suppose the doctor would keep the patient there. What do you suppose, if they could not get the care at a less expensive facility?

Mr. SKUTT. I think you are putting your finger on something that could be a contributing factor to improvement of the situation, more utilization of outpatient care, extended care facilities rather than the hospitals themselves.

Mr. SHARP. So really, the point I'm getting at here, how can deductibles, coinsurance really control the utilization of costs when they are imposed on the patient when it is the doctor really, for the most part I should say, who controls these costs?

Mr. SKUTT. Would you repeat that? I could not hear you.

Mr. SHARP. How can, then, deductibles, coinsurance, waiting periods, et cetera, control health service utilization or their costs when placed on a patient, because it is the doctor, really, who controls, for the most part, medical service utilization and their costs.

Mr. SKUTT. Well, I don't say that they can and I don't know whether anyone has asserted that they could, and the company's relationship with the doctor is not on a contractual basis, but it is with the patient, with the policyholder.

Now, if the policy has some deductibles in there on a reasonable basis—I am talking about those that don't leave any protection. I am not talking about reasonable provisions, that the patient has a little more incentive than perhaps in encouraging the doctor to let him go he would if the company is going to pay all of the bill instead of, say, 80 percent of it.

He has got a little more incentive to say, "Well, doctor, don't you think the time has come for me to leave you?" Is that clear? My point is that the insured has some interest in it whether it is a deductible or coinsurance.

Mr. SHARP. Well, he has an interest in it, but can he really exercise that interest? Can he really, if he is seriously ill in a hospital, and not just resting there, can he really exercise it? Do you have any opinion on that?

Mr. SKUTT. Well, of course, if he is that seriously ill, he is going to have to have his hospitalization and medical care.

I thought we were talking about those areas where improvement could be made now in reducing the utilization of hospital facilities by having people who didn't have to be in the hospital not stay there just because they wanted to or because the doctor hadn't released them.

Mr. SHARP. Do most of your policies give payment to the hospitals?

Mr. SKUTT. Direct to the hospital, did you say?

Mr. SHARP. Yes.

Mr. SKUTT. Payments, no. I believe our policies all pay direct to the insured. Now, where the insured makes an assignment to the hospital,

we recognize the assignment, but the policy contract is exclusively between the insured and Mutual of Omaha.

Mr. SHARP. Therefore, your company has basically no legal relationship with the doctors or hospitals—like the Blue Cross or Blue Shield do?

Mr. SKUTT. No, but we recognize the collateral responsibility, Counselor. Our people keep in touch with the hospitals and doctors, and in cases where it looks like something could be done to improve the situation, we make an effort to do so. That gets pretty close to this rehabilitation aspect of our operations that I mentioned earlier.

Mr. SHARP. Well, out of every 100 claims that your company paid, for example, in 1971, around how many would you cut back because of unnecessary doctor fees or hospital utilization? Do you have any figures on that? Do you have any idea out of every 100 claims?

Mr. HANSON. I wouldn't be able to guess for you. We have not compiled that information because we handle it on a per claim basis. When we see a claim, in the ordinary course of handling, that seems to indicate overutilization or overcharging or this sort of thing, we handle that particular item at that particular time and we go to medical societies, to review groups, to the sources that are available to us, and try to get those abuses taken care of.

We do go to the hospitals and visit with them. I couldn't give you the answer to how many out of 100. I don't—

Mr. SHARP. Well, according to the statistics you submitted to the subcommittee, you received somewhere in the neighborhood of 800,000 claims last year. How many adjusters or how many claims people do you have reviewing 800,000 claims—how many adjusters per claim? Do you have information on that basis?

Mr. HANSON. We certainly do; but you have to remember that one claim may be reviewed several times in the course of its development and I can give you the employee count with relationship to the number of claims. I'll be happy to give you that.

Mr. SHARP. Would you give us the administrative cost per claim for this type of review you are undertaking? We would appreciate it if you could submit for the record—

Re Mutual of Omaha—Response to Inquiry of Mr. Dean Sharp Transcript, Page 806, Lines 2-4.

In response to the request of Mr. Dean Sharp, Committee Subcounsel, the following information on administrative costs is submitted:

For the year in question, 1970, our administrative cost per claim check issued, exclusive of group insurance, was \$9.06. This figure includes all items of expense chargeable to the administration of claims.

In the consideration of this expense factor, it is important to remember, as indicated in previous communications, that the Company's system of claim file development and processing results in a conservatively stated total of claims received.

It is important, too, to realize that this expense factor applies to all kinds of claims; that is, loss of time, accidental death, hospital, surgical, medical, etc. While we do not have the administrative cost per claim broken down by kind of claim, it is evident that such cost per hospital, surgical or medical expense claim would be considerably lower than for loss of time or accidental death claims.

Finally, it should be borne in mind that the overall administrative cost of Mutual of Omaha is, year after year, among the lowest of all companies in the field. In 1970, for example, Mutual of Omaha's administrative costs were 35.2% lower than the combined average of the other major companies in the individual health insurance field who file such detailed data with insurance regulatory authorities.

Mr. HANSON. We will see what we can do.

Mr. SHARP. We can communicate with you later on this.

Mr. SKUTT. I will be happy to look into this and give you any figures we have on it.

Mr. SHARP. I will assume you have heard of Dr. John Knowles?

Mr. SKUTT. Yes.

Mr. SHARP. He is the new head of the Rockefeller Foundation, formerly the head of the Massachusetts General Hospital, Boston, a medical doctor himself.

Now, he said recently that doctors are making a killing in this country. Let's see, I'll quote exactly. Knowles said that "30 to 40 percent of American doctors are making a killing in their practice of medicine and that incredible amounts of unnecessary surgery are going on."

He says, "Unnecessary surgery is being done." Several "studies have shown wide differences in rates for surgery among people living within similar regions of this and in England. Also, he said, health maintenance organizations like Kaiser-Permanente in California that offer prepaid care need six general surgeons per 100,000 population, whereas the country at large supports 13 general surgeons for 100,000 people on a fee-for-service basis."

In using the phrase "making a killing," though, he said he did not mean a specific income level. Instead, he said, "some doctors earn salaries well above \$50,000 by virtue of excessive charges for use of technology such as laboratory, X-ray, and surgical equipment that a hospital generally buys for specialists."

Do you have any comment on this? What's your reaction to that kind of a statement by a prominent doctor like this?

[From the Evening Star, Washington, D.C., Mon., June 5, 1972]

"LONGSTANDING FEUD"—KNOWLES FACING REBUKE ON ETHICS

(By Lawrence K. Altman)

NEW YORK—Massachusetts Medical Society officials, in a move made rarely during the organization's 101-year history, are expected soon to censure Dr. John H. Knowles, who is due to become president of the Rockefeller Foundation here July 1.

The society's Committee on Ethics and Discipline said in a report that Knowles, who formerly directed Massachusetts General Hospital, had "acted in a manner unworthy of an honorable physician" by repeatedly declining to document to the society charges he had made publicly.

Knowles has said that "30 to 40 percent" of American doctors "are making a killing" in their practice of medicine and that "incredible amounts of unnecessary surgery are going on."

EARLIER CONTROVERSIES

Knowles also has been involved in national political controversies.

In 1969, he was denied the nomination as Health, Education, and Welfare assistant secretary for health and scientific affairs, the government's top medical post, after a five-month hassle in which the American Medical Association was credited with blocking his appointment.

The society said "that Dr. Knowles has done a disservice to the medical profession and to the laity by these general accusations in the public media and has in a sense tarred all his fellow practitioners with the '30 to 40 percent' brush."

Knowles said in a recent interview here that he was applying for a medical license in New York state. Officials said a censure was unlikely to influence such an application.

Intellectual Digest published Knowles' charges in its February issue. Knowles said he had repeated the message in newspapers and on television programs in Boston.

DIDN'T APPEAR

But because Knowles declined to appear before the committee, the society said it "cannot confirm or deny Dr. Knowles' statements because he was provided no data to support his comments and no references."

Further, the report said, there is "no knowledge of Dr. Knowles having ever brought a specific charge of wrongdoing by any particular physician to any committee of the society with appropriate documentation."

Dr. Thomas Gephart, medical society secretary, said in an interview from Boston:

"It's his method. We're not saying that he's wrong in what he says—it's that the way he did it is not in the best interests of the profession or the public."

Knowles said his refusal to discuss the statements with the society reflected a longstanding feud over several issues, including regional medical programs and compulsory membership in the AMA as a requirement for joining local medical societies.

Knowles emphasized that "70 percent of the doctors in this country are doing a fine job under very trying conditions, but I stand with the 30 percent figure. It's an estimate obviously because there's no way I can prove the figure."

Knowles said his estimate was based on several points—none new—that have been made in a variety of medical publications and are the basis of many heated debates on the complex socio-economic issues of medicine.

Unnecessary surgery is being done, he said, citing the fact that studies have shown wide differences in rates for surgery among people living within similar regions of this country and in England. Also, he said, health maintenance organizations like Kaiser-Permanente in California (that offer pre-paid care) need six general surgeons per 100,000 population, whereas the country at large supports 13 general surgeons for 100,000 people on a fee-for-service basis.

Some doctors have said that such statistics reflect the fact that too few operations are done in England and in some areas of this country where doctors are scarce. But Knowles contended that the statistics showed too much surgery is being done.

In using the phrase "making a killing," Knowles said he did not mean a specific income level. Instead, he said, some doctors earn salaries well above \$50,000 by virtue of excessive charges for use of technology such as laboratory, x-ray and surgical equipment that a hospital generally buys for specialists.

MR. SKUTT. I haven't seen that statement by Dr. Knowles. As I answered you earlier, I haven't heard it, but as far as the charges "in making a killing" and so forth, in the medical profession, as he described, I don't think that the doctors should be faulted for rendering the great service they have rendered.

Now, if, because of a shortage of doctors and the fact that they sometimes have to work around the clock to respond to the calls they have, that they are making more money than somebody thinks they should, why that's something else. But you are never going to get at the root of this problem, Counselor, until you have more doctors, more facilities, more people rendering medical and hospital care, and then the cost will take care of itself as it has in everything else in this country.

MR. SHARP. Well, do you feel that part of this problem could also be the result of the type of casual attitude of the insurance companies, just paying claims, really not getting at the cost of these claims?

MR. SKUTT. If you can visit our place, and you are cordially invited, right now, sometime, if you would like to stop over in Omaha and talk to some of our people, you will find that there is no casual attitude taken with respect to our responsibilities to policy owners.

We have made an enviable record in that field and we consider as part of that service, cooperation with the policyholder on any

matter which looks like—where it appears that he is not being treated fairly.

Now, on the other hand, we cannot usurp his prerogative. We cannot move in and talk to and tell the doctor that he is not treating this patient right, because this patient has a policy—we can try to cooperate with respect to controlling the cost, and we do that.

I mentioned, earlier, the telephone service that we have for the convenience of doctors, and by reason of that we have established a relationship with the medical profession, that and other things that we have done.

Our organization was founded by a doctor, a student at Creighton Medical College, Dr. C. C. Criss. Later there was associated with us as a director and chief medical consultant, the late great Dr. Charles W. Mayo, the last Mayo connected with Mayo Clinic. This Dr. Mayo was accidentally killed about 3 years ago, and he, as Mr. Hanson has stated has been active in helping us work with the profession, and we think we have done as much as any insurance institution in the country in endeavoring to meet these problems you discussed.

Mr. SHARP. You mentioned Dr. Charles Mayo?

Mr. SKUTT. Yes.

Mr. SHARP. Did you have—was there another Dr. Mayo associated a few months ago with your company?

Mr. SKUTT. Yes; that's right.

Mr. SHARP. I think he has resigned. Is he a member of the board?

Mr. SKUTT. No. Never was. No. He was with us just a short time, because he was the son of Dr. Charles W. Mayo and we had him working with us for a time. He was with us about—

Mr. SHARP. He resigned, did he not?

Mr. SKUTT. Well—

Mr. SHARP. I think he issued a statement, did he not, about the quality and quantity and type of care in this country and that he supports a different type of restructuring or different from which you—

Mr. SKUTT. Yes. I think he has—he left the Mayo Clinic. You know he is not identified with the Mayo Clinic at all, and I believe he is putting in his time on social programs.

Mr. SHARP. Now, about 90 percent of the premium dollar, let us say, as to group and in your company, 70 percent as to individual policy premium dollar is being passed on as paying for the medical costs, right—for the underlying hospital and medical costs?

Mr. SKUTT. Yes.

Mr. SHARP. And we speak of competition among the insurance companies as increasing efficiency, or, as you would say, the company's premiums are made up of these costs, the 70 percent and the administrative costs of 30 percent.

Now, you would admit, and I think you have, that competition is not working with respect to doctors and hospitals. In fact, it is driving up the cost.

Just how does this competition among the insurance companies—how is it going to affect this doctor and hospital service cost? How is it going to drive these costs down—competition among individual insurance companies? How is this going to drive down the underlying doctor and hospital costs?

Mr. SKUTT. I think it just has: competition in the insurance field has been beneficial. But, you know, there are about 2,000, more or less, companies in the field, and I think it has put each company on its toes a little more to do a better job, and, perhaps, to give more protection for the money. at least our organization has made quite a record in the field, and I think we made a better record because we have competition than we would if we had not.

And I think that as more doctors are qualified and available, that you will find that your margin will be favorably affected.

Mr. SHARP. Now, you were kind enough, and we are not going into names, of submitting to us your three largest group cases. And we could not help but notice the rate increases since 1967 in these group cases. In your largest case here, you had a rate increase in 1967 of 5 percent; in 1968, 10 percent; 1969, 3 percent; 1970, 15 percent; and 1971, 8 percent.

You have another case here: 1967, 45 percent rate increase, none in 1968, 8 percent in 1969, 10 percent in 1970, 25 percent in 1971, nothing in 1972.

And the pattern seems to be not only in your company, but most of the 20 largest group carriers that we wrote to asking for their various rates, and it seems to indicate that what the insurance companies are doing is passing these costs on to the consumers, taxpayers, through the employers.

We are really not getting at the problem, are we, of controlling the utilization and the cost of doctor and hospital care?

Mr. SKUTT. Well, counselor, I think, with all due respect, most of your interrogation should be directed to the purveyors of hospital and medical care, rather than to insurance institutions who are endeavoring to help finance it.

Mr. SHARP. I can't hear.

Mr. SKUTT. I say that I feel that your questions are more appropriate for those who are engaged in providing health and hospital and medical care, than they are to us who are engaged in financing it.

We are doing the best we can, and the records show we are doing the best job in the country of meeting the needs of this by individuals and families.

And as far as getting at the exact reason as to why some of these costs are excessive and, therefore, you have to charge more premiums for the coverages, I think you get back to this diagram that we offered you here. There is going to have to be more liaison, more coordination, more understanding between the purveyors of health care and those who finance it.

Mr. SHARP. But you are an insurance company, sir. You are the middleman between the purveyors and the patient. Is that not true?

Mr. SKUTT. We finance it. We help with the financing.

Mr. SHARP. You are financing and assisting, right?

Mr. SKUTT. We are helping finance it. That is right.

Mr. SHARP. You are helping to finance it. The Government has an input, and other forms, programs have an input.

Now, if this is the case, you are financing it, should you not be trying to use some of this financing leverage to control the underlying costs of the providers?

Mr. SKUTT. Yes, we have been doing that. I thought our record showed that. We are getting into the very root—trying to have more purveyors available and trying to do our part in bringing that about. And we do have liaison with the administrators of medical care, and the doctors, and the hospitals, and so forth.

And in these conversations that I have referred to, that take place on this phone service that we have had recording our people, our medical department, as well as our underwriting department and so forth, are constantly endeavoring to improve the relationship between the patient and the doctor so far as charges are concerned, where we can do it properly.

Re Mutnal of Omaha—Addenda to Comments of Mr. V. J. Skutt Transcript, Page 813, Line 7

In response to questions of Mr. Dean Sharp regarding efforts to control underlying costs of providers (of health care).

The Executive Committee of the Board recognized the responsibility of our own organization to help control costs by preventing fraudulent, unethical or unprofessional conduct as early as 1957 when they authorized organization of the Special Services Division effective July 1, 1957. Since its inception, the Division has been under the direction of our General Legal Solicitor, who served as a Special Agent of the Federal Bureau of Investigation prior to joining our organization.

Among the activities of this Division from its inception are the following:

1. Personal contact with individual providers in case of obvious overcharges or fictitious charges to eliminate such practices and to effect restitution of monies wrongfully paid.

2. Personal contact with institutions in cases of irregular practices or overcharges with review of pertinent hospital records and personal discussion with individual staff members to eliminate such practices and provide for restitution of monies paid when appropriate.

3. Cooperate with Federal, State and Local Law Enforcement Agencies or Administrative Agencies.

4. Investigate and take appropriate action on any irregular or improper field activity.

This Division has worked diligently through the years to cope with problems including falsified and exaggerated claims from all sources as a part of its routine and regular procedures.

The efforts of this Division have been substantial in controlling provider costs.

Mr. SHARP. Well, have you ever tried—has your company ever tried to renegotiate contracts with hospitals, like Blue Cross does with hospitals, in very large cases or group policies? Have you ever attempted this?

Mr. SKUTT. Yes. We have had relations with hospitals—I can't name them right now. That would be a matter for our claim department. But we could furnish you some information on that.

And getting back to your question on group insurance, we could furnish you some information on our cost studies, our efforts to help control costs, Mr. Sharp, in the group area. And if you care to have some more material from us, I will see that we can get that to you.

Mr. SHARP. Perhaps you could submit some examples of negotiated contracts, where you have actually negotiated a contract with a hospital or a group of doctors.

Mr. SKUTT. Yes.

Mr. SHARP. That would be very helpful, sir. We would appreciate that.

Now our understanding is that you are a mutual insurance company. Most people have a lot of difficulty understanding the difference between a mutual and a stock company.

What is basically mutual insurance company?

Mr. SKUTT. Well, of course, a mutual insurance company is an insurance company which is owned by its policy owners. The reserves maintained, in keeping with the statutory requirements, are reserved to meet obligations to those policy owners.

And a stock company is a company that is owned by stockholders. It has an obligation to meet its contracts of policyholders, but it is owned—the company itself is owned by the stockholders.

Mr. SHARP. You were also very kind in that you submitted to this subcommittee data showing the percentages and amounts of loans to hospitals facilities, convalescent homes, medical buildings, and other health facilities, which shows that over a 6-year period that your company has loaned, at various rates of interest, to some hospitals, and as I said convalescent homes, et cetera, some \$2½ million a year.

This comes out, based on the amount of invested assets and cash you have, as less than one-half of 1 percent.

If you are interested, as a mutual insurance company, in the welfare of the mutual policyholders, and you are attempting, as you say, to have their interest at heart, as far as health care is concerned, and you are attempting to promote the care that you mentioned through loans and other things you are doing to control some of these costs, how do you explain such a low rate of investment in health care facilities?

Mr. SKUTT. Well, I don't happen to have an investment officer with us this morning, and I am not familiar with the applications that have been received for loans.

I would doubt that there have been any applications received for financing of any hospital or medical facility that we have had, that we have turned away without a careful examination of it.

I do know that in a Creighton facility, the new hospital and so on, that has been discussed here earlier, that we are involved—totally involved in that, and another, Clarkson Hospital, and—up there in Omaha, we made a substantial loan and we made substantial loans around the country, and I am sure that we will give due consideration—our investment department—to any other demand of that character.

Mr. SHARP. Well, I mention this, because you indicated that was a good idea for the Government to make the loans, you know, to build schools and what have you.

Mr. SKUTT. Yes.

Mr. SHARP. And since you don't have stockholders, you do have mutual policyholders who control the company, you are almost in the same position as government, in essence.

Mr. SKUTT. Something we don't have is a taxing power. We do not have taxing power and that makes quite a difference.

Mr. SHARP. But you do collect premiums?

Mr. SKUTT. That is right. That is all on a voluntary basis. It is not a mandatory business.

Senator HRUSKA. Mr. Sharp, will you yield on that point?

Mr. Skutt, as a matter of fact you do have taxing power, but it is applied only to those to whom you have contractual relationships through policies. Is that not correct?

Mr. SKUTT. Except that is optional with the insurer. I do not think it is optional with the taxpayer, Senator.

Senator HRUSKA. That is right. It is a voluntary relationship, but if you were called upon to lend the money at less than the market rates, for hospital and medical facilities, it would not be the taxpayers at large, over the country, who would do that, it would be those individuals.

You would be spending the money accumulated from those individuals with whom you had entered into voluntary contractual arrangements.

Mr. SKUTT. Exactly.

Senator HRUSKA. Now, if all of those members would have access to the hospitals you favored by money rates less than the market, that would be one thing. But if you would be furnishing that type of money at a lesser cost than the market value, and other companies' voluntary contractual contractees would get into that picture, that is something else again, is it not?

Mr. SKUTT. Exactly. Right. And your investment return is very important in filling out the obligations to meet them.

Senator HRUSKA. To spend the money, either the surplus or the reserve of your policyholders to give away to medical and hospital facilities, would not be a favor to those policyholders?

Mr. SKUTT. That's right, sir. Right. That's a good point.

We have the first responsibility of the funds, and we must show a reasonable return.

Senator HRUSKA. And furthermore, would the insurance departments of your States allow you to lend money for less than the market value of money at any given time?

Mr. SKUTT. I doubt they would, Senator. At least, we'd lay ourselves open to great criticisms if we did not invest the funds of the policyholders prudently with an adequate return.

Senator HRUSKA. It would be a gift of money, and that money is not yours, that money belongs to your policyholders.

Mr. SKUTT. That's right.

Senator HRUSKA. And there are some rather stringent statutes, are there not, governing investment of funds and what they can be invested in and what they cannot be invested in?

Mr. SKUTT. Absolutely correct.

Senator HRUSKA. Thank you, counsel.

Mr. SHARP. Along that line, you loaned money, for example, in 1970, for a medical office building at the rate of 8 percent; mortgage bond loans, for example, to build a hospital in Lowell, Mass., in 1971; 9¼ percent rate of interest, and in Omaha, Nebr., there's a bond with your company—I guess that's correct—to build a hospital, at 10 percent rate of interest. Do you feel that these interest rates are below market?

Mr. SKUTT. I couldn't answer that, counselor, without looking at the figures and having the advice of our investment department people.

Mr. SHARP. Senator, I just want to introduce this sheet of figures that was provided by Mutual of Omaha into the record.

Mr. SKUTT. And may I have the privilege of filing any explanatory data that our investment department may feel is pertinent?

(Material follows. Testimony resumes on p. 1256.)

MEMORANDUM

Subject: Statement of Mr. V. J. Skutt, chairman of the board, Mutual of Omaha Insurance Company, Omaha, Nebraska.

On lines 13/20, page S15, Mr. Sharp inquired, "If you are interested as a mutual insurance company in the welfare of the mutual policyholders, and you are attempting, as you say, to have their interest at heart, as far as health care is concerned, and you are attempting to promote the care that you mentioned, the loans and two other things, that you try to control some of these costs, *how do you explain such a low rate of investment in health care facilities?*"

Also, on lines 19/25, page S18, continued on line 1, page S19, Mr. Sharp stated and inquired, "Along that line, you loaned money, for example, in 1970, for a medical office building at the rate of 8 percent; mortgage bond loans here, for example, to build a hospital in Lowell, Massachusetts, in 1971, 9¼ percent rate of interest; and, in Omaha, Nebraska, there's a bond with your company—I guess that's correct—to build a hospital, at 10 percent rate of interest. *Do you feel that these interest rates are below market?*"

On lines 1/3, page S20, Mr. Skutt said, "And may I have the privilege of filing any explanatory data that our Investment Department may feel is pertinent?"

In order to provide an answer to the questions raised by Mr. Sharp, we believe it is necessary to summarize the investment policy of the Company which we will attempt to do as briefly as possible, as follows:

It is the investment policy and objective of United Benefit Life Insurance Company (an affiliate of Mutual of Omaha which owns the investments referred to on page S18) to invest its available funds at the highest possible rate of return, commensurate with the investment risk involved. Because most funds invested are for required reserves for our life insurance policyowners, it is our objective to make investments secured by good to prime quality credits as determined by our analysis; we avoid above-average risk investments. We received and also seek investment offerings from many different sources and consider all those offerings which meet our investment policy and objectives, including those in the Medical and the Health Care field. We substantiate the statement of Mr. Skutt beginning at the bottom of page S15: "I would doubt that there have been any applications received for financing of any hospital or medical facility that we have had, that we have turned away without a careful examination of it." The fact that this type investment is a small percentage of our investment assets can be attributed to the small percentage of these type investments available related to all other type investments, and also to the fact that some of those which are available from time to time do not meet our investment policy, either as to investment quality, maturity, call protection or rate of return.

It is *not* the policy, practice, or intention of our Company to commit for investments at below market rates. The rates on the loans submitted with the Statement (page S19, Item III.B.1) were made under widely varying money market and securities market conditions and represent credits differing considerably from a quality standpoint; some are municipal bonds purchased by Mutual of Omaha. The particular investments referred to by Mr. Sharp on Page S18 are those made by United Benefit. Having reviewed money and securities markets at the time these particular investment commitments were made and taking into consideration the type issues and quality of credits involved, we believe that these rates in each instance were reasonable and appropriate at the time for both the issuers and the lender. We are prepared to substantiate this belief in detail if it would be helpful to the Sub-Committee.

M. T. CRUMMER,
Financial Vice President and Treasurer.

MEMORANDUM

Subject: Bishop Clarkson Memorial Hospital.

On December 4, 1969 the Investment Committee of United Benefit approved purchase of \$625,000, 10% First Mortgage Notes to be issued by Bishop Clarkson Memorial Hospital. Said notes are part of a total issue of \$3,000,000 and are due eight years from the date the loan is closed. A semi-annual sinking fund of \$375,000 which begins 12-15-74 is scheduled to retire the issue at maturity. This loan was acquired on July 7, 1970 on a direct placement basis from the Hospital

which was represented in the negotiations primarily by Mr. Morris Miller, the then and still Chairman of the Omaha National Bank. Incidentally, Mr. Miller's background with the bank included many years as a lending officer and he has an extremely favorable reputation in this capacity. Other participants in this financing are the Aetna Casualty and Surety Company for \$2,000,000 and Woodmen of the World Life Insurance Society for \$375,000.

The proceeds from this loan plus approximately \$600,000 from bank financing, plus internal cash flow will be used to complete the major hospital expansion and renovation begun in 1967, the total cost of which is approximately \$18,500,000, compared to an original estimate of approximately \$15,000,000. In June of 1967 the same lenders had committed to purchase \$8,000,000 6½% First Mortgage Notes due in 20 years as follows: Aetna \$5.5 million, United Benefit \$1.5 million and Woodman \$1 million. These notes were issued 1-31-68 and United Benefit's loan has been paid down to \$1,260,938 at the present time.

The question has been raised as to why the \$3,000,000 Notes issued in 1970 bear such a high rate of interest as 10%. A review of bond market conditions at the time during which this loan was negotiated would quickly lead anyone knowledgeable in money market and security markets to the conclusion that this rate for this credit at this time was most reasonable and appropriate. We have the information to substantiate this conclusion if requested to do so. In a letter dated January 5, 1970, when acknowledging our approval to purchase \$625,000 10% Notes of the Hospital, Mr. Miller, as a representative of the Hospital Board, stated: "In these times of terribly tight money, to express other than gratefulness would be grossly inappropriate."

Securities market conditions during the time this loan was being negotiated can be summarized as follows: money was extremely tight; interest rates were rising and during the latter part of 1969 reached their highest level in more than 150 years—see Chart attached (they were to go even higher to mid-1970); and a reverse yield curve existed at the time (for example: In December 1969 the yield on a four year government was 8.24% vs. 7.49% in 10 years and 6.90% in 20 years).

Having reviewed our file and security market conditions at the time this loan was negotiated, I am of the opinion that we can unquestionably demonstrate to any interested, reasonable party with an objective viewpoint that the rate on this Note at this time was very reasonable from the standpoint of the issuer. I also believe that we could obtain, if necessary, a statement to this effect from the Board of Directors of the Bishop Clarkson Memorial Hospital.

M. T. CRUMMER,

Financial Vice President and Treasurer.

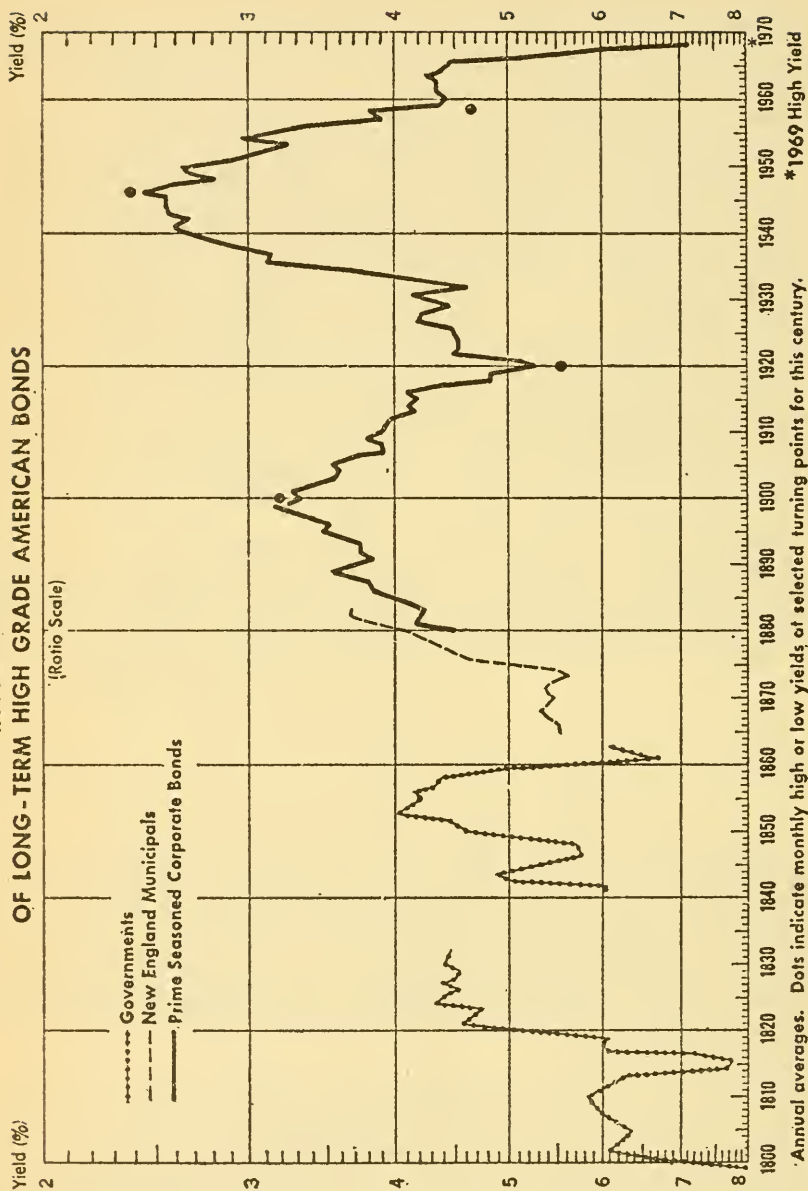
[Excerpt from "Annual Review of the Bond Market, 1969," Salomon Brothers & Hutzler]

SHORT-TERM INTEREST RATES AND THE YIELD CURVE

Short-term interest rates also rose spectacularly from September of 1968 throughout most of 1969. During this period, 3-month Treasury bill rates rose 313 basis points, while 3-month commercial paper rates rose 337 basis points (see Table IV). This escalation carried short-term rates up to new highs for the postwar period, which were very substantially above earlier postwar highs. However, the resulting short-term rates at 8% to 10% are not as historically unusual as present long-term bond yields. This is because in the 1920's and earlier, in periods of money crisis, short-term rates soared to extremely high levels; for example, call money reached 20% in 1929, 30% in 1919, and 125% in the panic of 1907.

A great deal of the immediate money market pressure during 1969 fell first upon the markets for Federal funds and for Euro-dollars. These two markets were the chief source of new funds for the large money market banks during early 1969, and borrowings in these markets helped them to finance the runoff in certificates of deposit. During the second half of 1969, bank commercial paper became another important source. Chart IV shows the sharp rise in both Federal funds rates and Euro-dollar rates in the first half of 1969 and that this was followed by irregular zigzags later in the year. Although the chart shows that the June peak in 3-month Euro-dollars was about 11.40%, it is reported that some other maturities of Euro-dollars traded at that time as high as 13% and again towards year-end. Chart IV shows that the 3-month bill rates did not rise much during the first half of 1969, but rose spectacularly during the second half year.

Chart III
INVERTED YIELDS
OF LONG-TERM HIGH GRADE AMERICAN BONDS



BISHOP CLARKSON MEMORIAL HOSPITAL LOAN OFFERING, DECEMBER 3, 1969

OFFERING

We have been offered a participation in an additional loan of \$3 million to Clarkson. The offer is made directly through Morris Miller, Chairman, Omaha National Bank representing the Clarkson Board. Aetna is considering \$2 million, Woodmen \$375,000 and we have been asked to look at \$625,000. An Aetna representative was to visit Clarkson on December 2. A final negotiation of terms and a decision from Aetna is expected shortly.

HOLDING

We own \$1,462,500, 6½% First Mortgage Bonds due semiannually to 1988. A schedule of loan terms for the initial issue is attached.

PROPOSED TERMS

Amount: \$3 million.

Rate: 10%.

Term: 8 years.

Prepayment: Interest only for 4 years and \$750,000 annually in the 5th through 8th years. Average life—6.5 years.

Call: This term is being negotiated. Aetna has suggested the loan be non-callable for the full eight years. Morris Miller wishes to negotiate. The hospital management has indicated certain funds held in trust might become available. We favor use of excess funds in the repayment of the original issue.

Security: The issue would share equally in the First Mortgage and additional terms of our outstanding loan.

Payout: June 1970.

Additional Debt: The indenture will be modified to permit up to \$600,000 of short term debt.

CLARKSON HOSPITAL LOAN OFFERING, DECEMBER 3, 1969

CREDIT

The hospital negotiated an \$8 million loan in 1967 to finance the construction of a new wing and the renovation of the old wing. We acquired \$1,500,000 (18.75%) of that issue. The hospital is now seeking an additional \$3 million. This financing is necessary for two main reasons—costs have exceeded budgets and cash flows have been lower than expected, based on projections prepared at the time of the 1967 offering.

SCHEDULE OF COST OVERRUNS

	Budget	Current status	Change
CONSTRUCTION PROGRAM			
Building contract.....	\$12,331,960	\$13,624,190	\$1,292,500
Architects contract.....	765,465	923,700	158,155
Movable equipment.....	1,250,000	1,767,000	517,000
Exterior decor.....	147,000	147,000	-----
Landscaping.....	30,000	30,000	-----
Other costs (preliminary).....	11,550	25,605	14,055
Interim financing.....	450,000	472,260	22,260
Replace incinerator.....	-----	52,400	52,400
Improve steam line.....	-----	125,000	125,000
OTHER COSTS			
Parking lot (real estate).....	-----	537,000	537,000
Parking lot (construction).....	-----	43,210	43,210
Acquisition agreement [Mar. 1, 1970].....	-----	700,000	700,000
Total.....	14,985,785	18,447,365	3,461,580

SCHEDULE OF REMAINING CASH NEEDS

	Total cost	Payments made to date	Balance due
CONSTRUCTION PROGRAM			
Building contract.....	\$13,624,190	\$10,752,600	\$2,871,590
Architect contract.....	923,700	794,575	129,125
Movable equipment.....	1,767,000	741,010	1,025,990
Exterior decor.....	147,000	58,170	88,830
Landscaping.....	30,000	25,230	4,770
Other costs (preliminary).....	25,605	25,605	-----
Interim financing.....	472,260	369,860	102,400
Replace incinerator.....	52,400	46,000	6,400
Steam line improvement.....	125,000	-----	125,000
OTHER COSTS			
Parking lot (real estate).....	537,000	290,000	247,000
Parking lot (construction).....	43,210	43,210	-----
Acquisition agreement.....	700,000	-----	700,000
Total.....	18,447,365	13,146,260	5,301,105

The balance due is actually comprised of an increase in costs of \$3,461,580 and a payment deficit of \$1,839,525.

The increase in the costs appears to be justified. While some of the costs increased due to deficiencies in the original plans (no plans for parking lots, steam line changes not anticipated), the majority of increases are due to deliberate changes in the plans (movable equipment increases, increases in building contract, etc.). Many of these deliberate changes have come in response to gifts, which generally specify the items for which they may be spent, and usually require additional funds on the part of the hospital. Two sizeable changes involved the Pavilion and entry and the cardiac care center, which necessitated most of the increased expenditure for movable equipment. While items like this were not in the original plans, the hospital management believes it is most fortunate to be able to add them to the facility at the same time other construction is being done.

Another major scheduled increase is the acquisition agreement. Under the terms of this agreement the hospital will acquire land across 42nd street for \$700,000. The hospital has another agreement with the University of Nebraska to sell the land for \$1,000,000. The legislature has appropriated funds and the transaction will produce a \$300,000 gain sometime in 1970.

Lower cash flows have resulted from smaller margins than were projected in 1967. There are two main reasons for this—expenses have grown more rapidly than anticipated, and due to delays in completing construction, patient days are currently running about a year behind projections. The major expenses problems have resulted from providing the increased utility load needed for an additional wing, but not having the wing completed for use with resulting off-setting revenues. Utility costs increased by more than \$250,000 so far in 1969. Once the wings are completely in use, the relationship between revenues and expenses should return to a more normal pattern.

This raises the question of the validity of the 1967 projections and the current revisions. The 1967 projections showed sufficient income to service the original debt, meet operating expenses and provide a small cushion of net profit. Actual results for 1967 and 1968 show that these projections have not been met, although the hospital has shown a net profit for these years. The substantial increase in revenues in 1968 reflects an increase in rates required to cover higher costs, primarily wages. The level of charges is well above that projected in 1966.

COMPARISON—ACTUAL AND PROJECTED OPERATING RESULTS, CLARKSON HOSPITAL LOAN OFFERING,
DEC 3, 1969

	1967		1968	
	Actual	Projection	Actual	Projection
Total revenues.....	\$6,739,073	\$6,440,201	\$8,209,891	\$6,799,842
Net profit.....	273,074	565,550	396,757	531,643
Operating expense.....	6,168,197	5,575,094	7,500,520	5,970,955

Another problem with the 1967 projections is the delay in finishing the new wing and renovating the old one have delayed the growth in anticipated patient days. Consequently, revenue and income projections are also out of line.

Clarkson's new projections (copy attached) reflect the increased expenses and delayed revenues. One immediate effect is that the 1967 projections have been set back about one year.

COMPARISON 1967 AND 1969 PROJECTIONS

	1969		1970		1971	
	1967 projection	1969 projection	1967 projection	1969 projection	1967 projection	1969 projection
Patient days.....	115,585	96,066	124,260	103,162	129,623	129,025
Total revenue.....	\$9,210,241	\$10,158,000	\$10,448,674	\$11,559,000	\$11,465,783	\$14,601,000
Net profit.....	\$184,816	\$119,000	\$157,299	(\$189,000)	\$269,807	\$1,467,000

Of greater importance, however, is the tremendous growth in net income predicted in the 1969 projections. Once the breakeven point is reached in early 1971, net income should grow by better than 20% a year. This provides a much greater margin of safety than was anticipated in the 1967 projections.

PROJECTED GROWTH—NET PROFIT AFTER INTEREST

	1969	1970	1971	1972	1973	1974
Net profit.....	\$119,000	(\$189,000)	\$1,467,000	\$1,676,000	\$2,307,000	\$2,648,000
Change (percent).....		(259)	876.2	14.2	37.6	14.8

The key to this growth in net income is the decline in expenses, particularly tached graph (attachment 1) from the breakeven year of 1970 until 1974, operating expenses declined from 91.6% to 78.7% of total revenue.

We raised questions about the validity of the projections. To answer these questions a meeting was held on November 25 with Mr. James Canedy, the administrator of Clarkson. The projected revenues are based on patient days growing through 1974 at a reasonable rate and conservative occupancy level (see Revenue & Expense Statement—5 Year Forecast). Per day charges are projected conservatively at approximately the current level with no increases after 1970. Expenses, primarily labor, decline as a percentage of revenue and on a per day basis as utilization picks up. The hospital is currently staffed on an administrative basis to handle a 50% larger occupancy. As patient days build up, the only additional labor expense should be direct nursing services. As a result, per day expenses should decline as fixed costs are spread over a much larger base. The hospital has developed a budgeting system that should provide a much closer control over expenses than was possible in the past. The projections appear reasonable and conservative. The control system should allow management to operate at the required cash flow level.

To substantiate this conclusion we also examined the statements of Bergan-Mercy Hospital, which is now operating with new facilities, and the projections of Lutheran Hospital, which is presently constructing new facilities. The results of this analysis, shown in attachment 2, indicate the Clarkson projections are in line.

Shown below is a projected coverage table. Once the breakeven point is reached in 1971, coverage increases substantially and provides adequate margins to service fixed charges.

PRO FORMA COVERAGE TABLE, CLARKSON HOSPITAL

[Dollar amounts in thousands]

	1970	1971	1972	1973	1974
Principal repayment.....	\$220	\$230	\$250	\$260	\$1,030
Interest expense.....	690	812	796	779	762
Total.....	910	1,042	1,046	1,039	1,792
Operating income.....	975	2,608	2,801	3,415	3,739
Coverage.....	1.1×	2.5×	2.7×	3.3×	2.1×

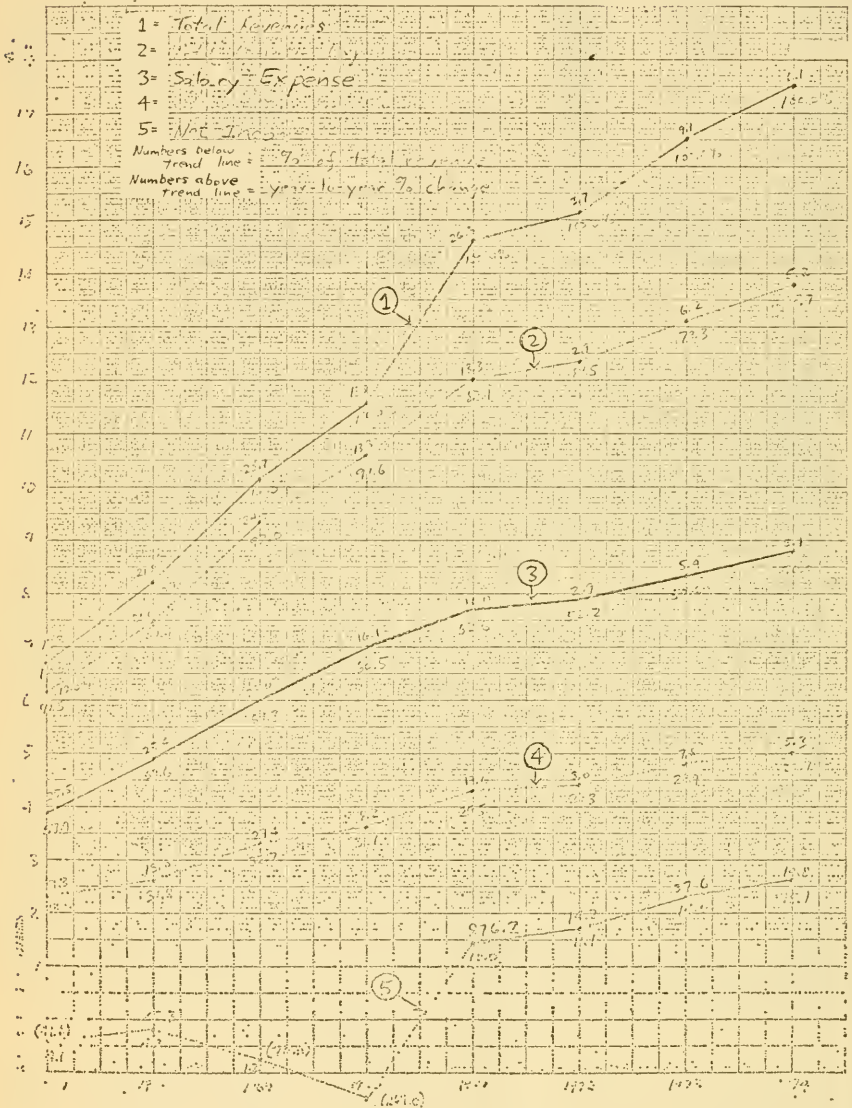
RECOMMENDATION

We recommend approval of an additional \$625,000 subject to final negotiation of satisfactory terms.

T. S. SCHMIT,
P. F. FRENZER.

CLARKSON HOSPITAL: Summary of Operating Statistics (%)

Attachment 1



BISHOP CLARKSON MEMORIAL HOSPITAL LOAN TERMS, JUNE 7, 1967

We have been requested to reconsider the Clarkson loan based on the following revised terms. Terms originally outlined in Aetna's commitment letter of November 1, 1966 are shown in parenthesis. Mr. Kiewit has reportedly approved the revised terms and recommended acceptance to the Hospital Board. Woodmen has been contacted but has not yet presented the revisions to its Committee. Aetna will seek Committee approval on Friday, June 9. The Hospital Board will meet on June 8.

Amounts: \$8 million (\$7.5 million). Aetna: \$5,500,000 (\$5 million); United: \$1,500,000; Woodmen: \$1,000,000.

Maturity: 20 years from the date of final closing which will not be later than December 31, 1969. (December 31, 1968).

Rate: 6½% (6¾%).

Reduction of Issue: The issue may be reduced to a minimum of \$6 million prior to final closing.

Closing: Three closings are anticipated. United was originally scheduled to take the entire first closing but Aetna is now willing to participate in a 1967 payout. The closing schedule is flexible and will be set after discussion among the lenders.

Commitment Fee: ½ of 1% annually from signing of the commitment letter.

Call: (1) Nonrefundable for 10 years (20 years). (2) Callable in inverse order in the first year at 104% declining ½ of 1% per year to par. (3) Prepayments without penalty.

(a) \$500,000 annually cumulative to \$1 million (non-cumulative);

(b) \$1 million from a specific trust;

(c) \$1.5 million from potential Hill-Burton grants. (New provision).

Prepayment: Semi-annual principal payment will retire the issue by maturity.

Debt Restriction: Additional long term debt is prohibited. If the lenders refuse to allow additional debt of \$1 million or more, the Hospital may prepay at par if the Hospital has a bona fide offer of an amount sufficient to retire outstanding debt plus the requested increase. Current debt will be limited to a maximum of \$500,000 with a required clean up of 45 days in each 12 month period.

Liens and encumbrances: Prohibited except up to \$250,000.

Security: First mortgage on all property except the Nursing School facility presently pledged.

PETER F. FRENZER.

ATTACHMENT 2

COMPARATIVE OPERATING RESULTS

[Percentages]

		1969		1971			1972		1973	
	1968 Bergan Mercy ¹	Clark- son ²	Bergan Mercy ¹	Clark- son ²	Luth- eran ²	Clark- son ²	Luth- eran ²	Clark- son ²	Luth- eran ²	Clark- son
Total revenues.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Operating expenses.....	81.9	92.0	80.3	91.6	84.4	82.1	82.0	81.5	79.3	79.3
Depreciation.....	5.3	3.0	4.8	5.4	6.5	4.3	5.2	4.2	4.3	3.8
Interest.....	3.5	3.8	2.8	4.7	12.3	3.5	9.9	3.3	8.2	2.9
Net income.....	9.3	1.2	12.2	(1.6)	(3.2)	10.0	2.9	11.1	8.1	14.0
Operating expenses:										
Salaries.....	47.4	59.3	47.4	60.5	48.1	52.6	47.5	52.2	46.0	50.4
Other.....	34.5	32.7	32.8	31.1	36.3	29.5	34.4	29.3	32.2	28.9
Year-to-year change:										
Total revenues.....			20.4	13.8	-----	26.3	24.0	3.7	20.4	9.1
Salaries.....			20.4	16.1	-----	10.0	22.4	2.9	16.6	5.4
Other operating Ex. O.....			14.5	8.2	-----	19.6	17.7	3.0	12.6	7.8
Net income.....			57.8	(259.6)	-----	876.2	211.9	14.2	339.9	37.6

¹ Actual.

² Projected.

BISHOP CLARKSON MEMORIAL HOSPITAL REVENUE AND EXPENSE STATEMENT, 5-YEAR FORECAST

[Dollar amounts in thousands]

	1969 amount	1970 amount	1971 amount	1972 amount	1973 amount	1974 amount
Revenue:						
Routine services.....	\$4,620	\$5,387	\$6,884	\$7,134	\$7,795	\$8,266
Special services.....	5,687	6,349	7,936	8,218	8,974	9,535
Gross patient revenue.....	10,307	11,736	14,820	15,352	16,769	17,801
Less deductions.....	674	749	937	970	1,059	1,126
Net patient revenue.....	9,633	10,987	13,883	14,382	15,710	16,675
Other revenue.....	575	572	718	765	821	862
Total operating revenue.....	10,158	11,559	14,601	15,147	16,531	17,537
Expenses:						
Employment cost.....	6,022	6,990	7,693	7,916	8,340	8,767
Other expense.....	3,321	3,594	4,300	4,430	4,776	5,031
Total operating expense.....	9,343	10,584	11,993	12,346	13,116	13,798
Net operating return.....	815	975	2,608	2,801	3,415	3,739
Other cost:						
Depreciation—Regular.....	305	300	300	300	300	300
Depreciation—New construction.....	—	324	329	329	329	329
Interest expense.....	391	540	512	496	479	462
Net income.....	119	(189)	1,467	1,676	2,307	2,648
Operating statistics:						
Patient days.....	96,066	103,162	129,025	133,598	145,895	155,018
Percent of occupancy.....	75.8	77.9	73.3	74.6	74.7	77.6
Payroll hours.....	2,156	2,207	2,406	2,450	2,509	2,569
FTE.....	1,036.0	1,090.5	1,171.5	1,173.5	1,206.05	1,230.5
Ratios (per patient day):						
Net patient revenue.....	100.27	106.46	107.60	107.65	107.68	107.57
Expenses less depreciation and interest.....	97.26	102.44	92.95	92.41	89.90	89.00
Payroll hours.....	22.4	21.4	19.0	18.3	17.2	16.6
Salaries per payroll hour.....	2.79	3.16	3.19	3.23	3.32	3.4
Percent expenses to revenue.....	98.8	91.5	90.2	89.3	86.4	85.4
Percent net income/total revenue.....	1.2	(1.64)	10.0	11.1	14.0	15.1

BISHOP CLARKSON MEMORIAL HOSPITAL STATEMENT OF CASH FLOW, 5-YEAR FORECAST

(In thousands of dollars)

	1970	1971	1972	1973	1974
OPERATING FUND					
Beginning cash balance.....	(161)	47	75	17	870
Sources:					
Net cash from operations.....	232	1,621	1,842	2,428	2,675
1st mortgage interest accrued.....	540				
90-day notes payable.....	550	(550)			
Transfer from plant funds.....		200	200		
Total of sources.....	1,322	1,271	2,042	2,428	2,675
Total cash available.....	1,161	1,318	2,117	2,445	3,545
Uses:					
Equipment purchases.....	192	134	210	100	140
1st mortgage interest.....	530	45			
1st mortgage principal.....	220	230	250	260	280
Additional mortgage interest.....	135	270	225	99	
Additional mortgage principal.....		500	1,400	1,100	
90-day notes interest.....	14	49			
Dormitory principal and interest.....	17	9	9	10	10
Dormitory maintenance.....	6	6	6	6	6
Total cash uses.....	1,114	1,243	2,100	1,575	436
Ending cash balance.....	47	75	17	870	3,109
PLANT FUND					
Beginning cash balance and government securities.....	733	65	78	6	7
Sources:					
Other income.....	12	12	12	12	12
Fund raising collections.....	476	210	117	193	198
Additional mortgage note.....	3,000				
Total of sources.....	3,488	222	129	210	210
Total cash available.....	4,221	287	207	216	217
Uses:					
Amortization of fund raising cost.....	15	9	1	1	1
Real estate mortgage.....	7			120	120
Construction contract.....	2,872				
Interim financing.....	102				
Architect fees.....	129				
Movable equipment.....	1,026				
Landscaping.....	5				
Exterior decor.....				88	
Transfer to operation.....		200	200		
Total cash uses.....	4,156	209	201	209	121
Ending cash balance and government securities.....	65	78	6	7	96
Combined ending cash balance and government securities for operating and plant funds.....	112	53	23	77	3,205

¹ Bad debt writeoff probable.² Purchase of 2 properties facing 42nd Street, block 16 of Highland Place.³ Purchase of Phyl Rho house, last property on block 16.

THE OMAHA NATIONAL BANK.

January 5, 1970.

Mr. PETER F. FRENZER,
Vice President, Securities,
United Benefit Life Insurance Co., Omaha, Nebr.

DEAR PETE: Thanks for your December 31 advice that your Investment Committee had approved a loan of \$625,000 to Bishop Clarkson Memorial Hospital in addition to the loan presently outstanding. In these times of terribly tight money, to express other than gratefulness, would be grossly inappropriate.

And yet, as I indicated to you on the phone, I would respectfully request that your Investment Committee reconsider the prepayment provisions which in your commitment are more stringent than those required by Aetna.

We are dealing with a nonprofit corporation so that the increased expenses are a direct burden upon our operations without benefit of tax deduction. Because we know Clarkson is to be the beneficiary of several important legacies and because of the impossibility of predicting time of receipt of those, we projected our cash flow without taking this item into consideration. When in the event we do realize some extra cash, it would obviously be of some advantage to the hospital to be able to apply it proportionately between the two loans rather than entirely on the lower rate transaction.

The Clarkson Board meets on Thursday, January 8, and I expect will authorize me to accept the commitment in accordance with its original terms, should your committee not be willing to change its mind. But we would appreciate the committee reexamining its position and will appreciate and abide by any decision reached.

Thanks for listening and best regards.

Sincerely,

MORRIS F. MILLER,
Chairman.

THE OMAHA NATIONAL BANK,
 January 16, 1970.

Mr. H. J. GOODRICH,
Investment Officer, Aetna Casualty & Surety Co.,
Hartford, Conn.

Mr. PETER F. FRENZER,
Vice President,
United Benefit Life Insurance Co., Omaha, Nebr.

Mr. THEODORE W. REHMANN, Jr.,
Investment Manager,
Woodmen of the World Life Insurance Society, Omaha, Nebr.

Gentlemen: I am returning herewith a signed copy to each of you of your commitment letters in connection with the \$3 million additional mortgage money needed by Bishop Clarkson Memorial Hospital. Under your commitment letters, Aetna has agreed to take \$2 million. United \$625,000, and Woodmen \$375,000.

The outline of the principal terms is almost identical from each of you. United spells out a little more clearly the definition of "pro rata" under the optional prepayment provisions, but I think this was done by Pete Frenzer after talking to Hoyt Goodrich and certainly the further clarification in the United outline is in accordance with the hospital's understanding of what was meant by the Aetna term.

We presume that the three of you will coordinate the drawing of the necessary papers so that timely disbursement may be made on this commitment on or about June 17. I shall be most happy to be of any further service to you that I can, and I know that Jim Canedy is prepared to work with each and all of you on the details.

The Board of Directors of the hospital has requested that I express to each of you, and through you to your respective organizations, our deep appreciation for this help and support at a time when funds are certainly something less than plentifully available.

Sincerely,

MORRIS F. MILLER.

Mr. SHARP. Certainly. These are your figures—this is data—and certainly if you have any further amplification of these, we will be pleased to receive it.

Mr. Skutt, getting back to this point of competition among insurance companies, perhaps a company such as yours could agree that competition among the individual health insurers has stimulated a wide diversity of available policies, and you've spoken to this point.

Whether this is beneficial to consumers is not clear—other people have testified to the opposite effect here. Now, with respect to the price of individual health insurance policies, how does competition help provide regulation of premium charges when there is such a bewildering array of policies available?

Making comparisons is almost impossible except by the most sophisticated buyers. Isn't this really why a number of States have begun to regulate premiums under individual health policies in recent years?

Mr. SKUTT. Well, we've touched upon regulations, rates, standardization earlier. There really is an opportunity, and sufficient flexibility for competitive rates to be established, and they are established.

Now, the coverages that we offer are provided through salesmen as a rule, practically all our coverages are sold through individual salesmen. And we feel that's desirable.

I tried to touch upon that in the statement we filed with you because we feel that the very point you make, on the insured knowing what coverages he's got and what he's paying for, can best be communicated to him by an honest dedicated sales representative qualified as a field underwriter. And that's what we've done in our organization.

And if I may continue with that—

Mr. SHARP. Certainly.

Mr. SKUTT. We feel that there, the insured understands the coverage he's getting, understands the payment he's making, and so forth. And I believe, counselor, that gets to the point that you raised, unless I misunderstood you.

Mr. SHARP. I think we have a little misunderstanding. I'm not just referring to your company. I'm referring to 1,200 companies offering a bewildering array of policies.

I go out into the marketplace and I now compare the benefits offered under a given set of policies with premiums charged. And it's very, very difficult. Just going through material submitted by the 40 companies, to understand, to get a feeling for "Just what kind of a deal am I really getting?", benefits to the premiums of the various companies on all these different types of plans. Isn't it self-defeating, really, for competition? You need a knowledgeable buyer in a marketplace because it's one thing to have a knowledgeable agent and a knowledgeable insurance company, but if a buyer of an insurance policy is not sophisticated, or he's not knowledgeable, how is he to compare? How is he to—on the basis of his own judgment—not on what some agent tells him—going to make an intelligent judgment himself as to the benefits and prices of the various policies among the various companies?

Mr. SKUTT. Well, your critical comment in that respect is understandable, and I realize that there are a great many different types of coverages and so forth, and many of them difficult to understand.

I've tried to emphasize our approach to this, which is educated field representatives to explain them, and to make sure the policy holder understands it.

We write a letter after the policy has been issued and explain it again, and that's one reason that considering the total number of policyholders we have, that we have such a small amount of misunderstandings.

If you are, however, counselor, endeavoring to elicit a response from me, as to whether or not this committee, being the antitrust committee and so forth, should establish some restrictions on what kind of policies should be issued or what kind of practices should be pursued, I don't feel qualified to respond.

Mr. SHARP. I was getting at the problem at the point of sale. That is the crucial moment for this comparison shopping and buying, not after the sale. Do you get letters of explanation from a particular company, at the initial point of contact, let's say?

Mr. SKUTT. Don't you think we do quite a job of that. If you read this memorandum we filed showing our training program for our representatives, and requirements and so forth, and the satisfaction of our policyholders, as shown by a survey, and everything—

Mr. SHARP. Sir, please understand I'm not quarreling with you or your company. I'm raising this as a general proposition since you are one of the largest individual companies, but there are many others.

We are just trying to get into the record, now, your opinion as an experienced person in the individual health field, not just you personally, but as to the whole industry.

Mr. SKUTT. Well, if you wouldn't consider me immodest, I'd just as soon recommended that the other companies follow our practices.

I don't want to put any halos on myself here today, or our position, but that's the best that I can answer your question, sir.

Mr. SHARP. Thank you very much, Mr. Skutt.

Senator HART. Senator Hruska?

Senator HRUSKA. Mr. Skutt, you know, there is a country in this world where they don't have any bewildering and confusing choice of iceboxes. It is known as the United—what is it? The USSR. They make a day and a night at one time. They made an icebox. They used to make a television, and you had your choice of either having that television or having them at all if you can save enough money for you.

Will you suggest that in order to get away from the very confusing and bewildering and wealth of choices that maybe we ought to have the Government, in its wisdom, assemble people some place down here, downtown, and say that 208 million people in America don't need that many; we will choose three and they can have their choice. Would that be a happier solution than this bewilderment and confusion which has been described just a little bit ago?

Mr. SKUTT. Senator, I think you very well pointed out there are some disadvantages that go with anything in life and certainly there are far more advantages in the competitive system and freedom of choice better than any other system or monolithic program.

Senator HRUSKA. It would have to be done by statute, I presume, if we limited the number of policies. Do you know, in the industry, how many groups or committees that would be wise enough to choose a half dozen policies that would be standard and the rates would be standard? I don't know how that would be done with the different hazards involved, but let us simplify it and say, now, we'll just put all of this business judgment and all of the requirements of personal

needs in the hands of, say, six or 60, or say, 100 people, and they will prescribe for all of the insurance-buyer public.

Do you think that would be practical?

Mr. SKUTT. Of course not, and I think there is a great advantage for an individual policyowner to be able to select a certain type of coverage for him in this situation because of his family or financial obligations. Then one may be put in a different status.

But there is a great deal to recommend a variety of choice which you referred to.

Senator HRUSKA. But if there did occur a limitation to five or six policies, can you imagine somebody on this side of a venture like this berating you and saying, what's the matter with you, stifling competition like that, not catering to the needs of your public?

Mr. SKUTT. Yes.

Senator HRUSKA. And therefore you should be compelled to have more varieties of benefits and contracts. Could you imagine that happening?

Mr. SKUTT. Yes; I am sure that is what would happen if we had a limited number available that we would hear that argument.

Senator HRUSKA. You know, the buyer today, the customer today, is faced with all kinds of bewildering circumstances and confusing circumstances. There was a time when we could go into the corner grocery store and they didn't have more than 600 or 700 items on the shelf. Now, there are 10,000 or 12,000.

In the supermarkets, it is nothing but bewilderment and confusion. That is all it is.

Do you think it would be well to get back to that little corner grocery store where you would get rid of that confusion and have only 600 or 700 items to choose from?

Mr. SKUTT. I think that the variety of choice, the production of a great many types of products and availability of them, to our public, is one of the things that make us a very great country and giving opportunities that no other country provides.

Senator HRUSKA. There is the free market we have and the competitive system, and it seems that when we get competition, there are complaints about it and where there is no competition, there is a complaint that there is no competition.

Maybe it is a sort of a syndrome, a kind of contemporary syndrome; complain. Whatever you do, whatever the situation, complain or criticize, ostracize; that's the way to get ahead in the world. If that would be true, I would deplore it. I think most people would.

Mr. SKUTT. Thank you.

Senator HRUSKA. In regard to these 8-percent and 10-percent loans that your company might be making, I don't know what purpose is in the mind of the one who questioned that or who calls attention to it.

Is it the idea—could it be the idea that you are supposed to make loans for less than that when you are building hospitals, do you think?

Mr. SKUTT. Well, I think, you know, that our investment department has the responsibility to be abreast of current rates and we have already touched on that responsibility of developing the proper investment return for the policyholders which enables us to give them more coverage, as we do to our policyowners; it helps us to do it more than some of the others.

Senator HRUSKA. And suppose the market rate for a loan like that was 8 percent and your investment board would loan it for 2 percent; do you think it would be many days before you would be faced with a policyholder suit asking to oust all of the board of directors, including its chairman and anybody that had anything to do with it because they were mishandling investments of funds?

Mr. SKUTT. I think we would have a new investment department first.

Senator HRUSKA. Well, I thank you, Mr. Skutt, for your appearance.

Mr. SKUTT. Thank you, Mr. Chairman. Thank you.

Senator HART. I think that, of course, the wisdom for me is not to even suggest that there may be aspects to the Soviet health and delivery system that are superior to ours, but that is what Secretary Richardson testified to recently.

We do appreciate very much the cooperation from Mutual of Omaha and both of you. Thank you.

Mr. SKUTT. Thank you, sir.

Senator HART. For those who are concerned with our schedule, it is our plan to receive the testimony of Mrs. Hentges of Dubuque, Iowa before taking a recess. We will recess following her testimony and resume at 2 o'clock to receive the testimony from the Health Insurance Association. Under an order entered by the Senate, beginning at 1 o'clock and continuing until 4, the debate on the nomination of Mr. Kleindienst will begin and some members of the committee will be compelled to be on the floor during that time period.

MUTUAL OF OMAHA—UNDERWRITERS GUIDE OR UNDERWRITING APPRAISAL OF PHYSICAL HISTORIES AND OCCUPATIONAL RATINGS

FOREWORD

The great majority of newborn babies are brought into this world sound in body and mind. As life progresses and age increases, misfortunes by way of sickness and accident occur. Some of these misfortunes are of a minor nature, while others leave a permanent mark. Those who fall into the latter class become rated risks for insurance purposes. As such, they cannot purchase the health insurance they want and need at the same rates and/or benefits offered to those who are unimpaired.

This manual, "Underwriting Appraisal of Physical Histories," provides a guide to help you properly underwrite clients. It is divided into sections with the contents of each pertaining to one of the body systems or functions.

Listed alphabetically and briefly described in laymen's language are those impairments pertaining to each system which you will encounter most frequently. This is followed by normal underwriting requirements (attending physician's report) and the probable action which can be taken—policy issuance at regular rates or policy issuance with increased premium rates and/or special benefit limitations.

All impaired risk plans provide benefit limits of 100% applicable to named impairments. Benefits provided by the policy will be payable for preexisting impairments not excluded from coverage, for loss beginning at least 12 months after the policy date.

This manual does not apply to accident-only or dread disease coverage.

The following guide to the underwriting of impaired conditions deals with the methods mentioned above:

ALL COLUMNS

A "1" indicates that regular coverage and rates are applicable and benefits for the named "Benefit Limitation" will be covered for loss beginning at least 12 months after the policy date.

A number (#) sign indicates that a "Disease Elimination" rider must be used and regular coverage and rates are applicable.

If no plan is shown, regular coverage at regular rates may be applied for.

Column one.—Disability Income: One of four impaired risk plans (A, B, C, D) may be indicated. Rates for the plans are contained in separately identified schedules of rates.

Plan A—Lifetime Maximum Coverage, no special monthly benefit limit.

Plan B—Lifetime Maximum Coverage, no special monthly benefit limit.

Plan C—Ten-year or To Age 65 Maximum Coverage for sickness, \$1,000 monthly benefit limit.

Plan D—Five-year Maximum Coverage, \$300 monthly benefit limit.

Column Two.—Hospital Coverages (includes hospital room, hospital miscellaneous, surgical, in-hospital medical, outpatient, diagnostic and minor medical coverages)

One of four impaired risk plans (A, B, C, D) may be indicated. They vary from regular plans only as to rates. Rates for the plans are contained in separately identified schedules.

Column Three.—Catastrophe Coverages

Catastrophe Coverages are those which generally provide benefits of \$5,000 or more and are identified as "Major Hospital, Major Medical, Out-of-hospital Expense," or similar terms.

One of three impaired risk plans (A, B, C) may be shown. They vary from regular plans only as to rates. (The letter "N" indicates that a plan is not available). Rates for the plans are contained in separately identified schedules. The more seriously impaired risks generally do not qualify for these coverages.

In case of multiple impairments, the application should be submitted on the basis of the most severe condition. Changes in coverage to fit the circumstances of the individual may be necessary. The Home Office underwriters will define, as specifically as possible, the conditions that are restricted or limited.

It is not the Company's intent to provide coverage to those who are currently under extensive medical management.

Mutual of Omaha will continue to offer the best possible disability income protection and hospital-medical insurance to all applicants, consistent with past and present health. It is your responsibility to help toward this end by securing complete information with supporting medical data. Underwriting and Renewal Services Division will review and evaluate each case, always with the objective of issuing some form of coverage.

W. M. Moss,

Vice President and Chief Underwriter, May 5, 1970.

OCCUPATIONAL RATE MANUAL

This manual is provided as a tool to assist the salesman properly classify his risks, selling the correct coverages at correct rates, thus gaining for himself the advantage of "issued as applied for" policies.

The plan of coverage and the premium rate for accident and health coverages are based upon the hazard to which the individual is exposed. If you, as a salesman, classify your clients as indicated, you will be relieved of reselling and thus have more delivered policies—more earned commission.

All ratings refer to first-class operations with reasonably modern machinery and equipment and where adequate safety facilities and health programs exist. If any of these situations are not true, you should give all of the facts to the Home Office for a rating. Rating may be adjusted by the Home Office as indicated by experience or other circumstances.

If the applicant has more than one occupation, all must be named in the application. The occupation involving the greatest hazard determines the ratings. If the applicant engages in recreational activities or hobbies involving any hazardous exposure, rating must be made according to that hazard.

HEALTH AND ACCIDENT CLASSIFICATIONS

[P] and [S] Select Preferred and Select Standard classifications include male executives, professional risks and key personnel. The occupations shown as [P] or [S] indicate possible occupational qualifications as select risk categories such as corporation officers, members of boards of directors, chemicals, engineers, architects, geologists, CPAs, physicians, attorneys, etc.

Special circumstances could qualify many other occupations for consideration as Select. Individual consideration will be given to each application for Select classification.

"P"—Preferred Classification:

Preferred or "P" policies are sold to persons who do no manual labor or supervision thereof, but whose duties consist of clerical, sales, executive or professional work only.

"S"—Standard Classification:

Individuals in the Standard Classification encounter no unusual hazard but unlike the "Preferred", do some manual work.

"S+10%":

"S+20%"—means a percentage increase in the Standard premium.

Persons so classified may purchase an "S" or Standard contract with a percentage increase in premium. These individuals encounter more hazards in their occupation, either accident or health, than do the "S" Standard risks.

Important—Increase the initial premium by a percentage of the renewal premium.

Example of 10% Increase:

Renewal Premium-----	\$68.00
10% Increase-----	6.80
Total -----	<u>74.80</u>
First Premium-----	78.00
Increase (Same as for Renewal)-----	6.80
Total -----	<u>84.80</u>

"H"—means Hazardous.

Persons so classified encounter materially increased hazards.

"N"—indicates risks not acceptable.

The 3 digit number shown for each occupation is for Home Office statistical records and should not be put on the application.

Abrasive industry:

183 Superintendent, Foreman (supervising only and Inspector)-----	S
184 All Other Workers-----	H
045 Abstractor -----	P
046 Accountant -----	P

Acid Manufacture:

185 Acetic, carbolic, citric, lactic, oxalic, phosphoric-----	S
186 Other acid manufacture laborer-----	H
187 Skilled Workers-----	S
188 Acrobat -----	N
001 Actor -----	S
002 Actress -----	S
003 Actuary -----	P
065 Adjuster, Claim-----	P
066 Advertising Agent, Writing-----	P
067 Agent, County and Farm Demonstrators-----	S
068 Agent, Express-----	S
070 Agent, Sales-----	P

Agriculture—See Farming and Ranching

Airplane Industry

047 Office Duties, Management Officials-----	P
189 Factory Employees, all others not flying—Airport Personnel----	S

Pilot and Crew Members

048 Scheduled Airlines-----	S*
049 Charter or Industrial Pilot-----	*
050 Nonscheduled or Crop Duster-----	N

Animal Attendants and Trainer

520 Domestic -----	H
145 Wild Animals-----	N
177 Apartment House Manager and employees-----	S
071 Appraiser -----	P

*Individual consideration to cover any aviation hazard.

Architect

004	Not superintending construction.....	P
005	Superintending construction.....	S
051	Art Dealer.....	P
146	Artist.....	P
334	Asbestos Mill Reduction Worker.....	S
335	Asbestos Mill Reduction Foreman.....	S

Athlete (Professional)

006	Baseball.....	S
007	Basketball.....	S
008	Boxing.....	N
009	Football.....	N
010	Bowling.....	S
011	Golf.....	S
012	Jockey.....	N
013	Hockey.....	N
014	Tennis.....	S
015	Wrestling.....	N
016	Soccer.....	N
017	Swimming.....	S

Assayer

072	Above ground.....	P
073	Under ground.....	H
074	Assessor.....	
075	Astrologer.....	
075	Astronomer.....	
147	Attendant.....	S
025	Attorney.....	
190	Auctioneer (Except Livestock).....	P
046	Auditor.....	S
076	Author.....	S
514	Automobile Assembly Worker.....	S
191	Awning Maker or Repairer.....	S
192	Axman, Chairman, Rodman.....	S
142	Baby-sitter.....	S
077	Bacteriologist.....	
148	Baggage Porter.....	S
078	Bailiff.....	S
193	Baker (all classifications).....	S
107	Bank Teller (Officer and Examiner (administrative duties).....	
106	Bank Guard, Messenger.....	S
194	Barber.....	S
195	Bartender.....	S
006	Baseball Player (professional).....	S
007	Basketball Player (professional).....	P
196	Basket Maker or Weaver.....	S

Battery Manufacture

197	Mixers, Poster and Laborer.....	H
198	All others.....	S
199	Beautician, Beauty Shop Worker.....	S
116	Beekeeper.....	S
149	Bellhop.....	S
112	Bill Collector.....	P
089	Biographer.....	P
100	Biologist.....	S
018	Bishop, Priest, Clergy.....	P
200	Blacksmith.....	S
178	Boardinghouse Keeper.....	S

Boat and Ship Building

052	Superintendent or Proprietor (not Foreman, office duties only).....	
201	Carpenter, Foreman, Shipfitter, Skilled Workers.....	S
202	Crane Hooker, Rigger, Follower, Erector.....	H
203	Boilermaker.....	S

113	Bond and Stock Broker, Salesman	
108	Bookkeeper (not in home)	P
518	Booking Agent	P
150	Bootblack	S
008	Boxer	N
010	Bowling (professional)	S
204	Brickworker, Mason	S
Bridge Building		
205	Supervising only	S
206	Cableman, Painter, Structural Steel Worker	H
207	Others	S
208	Laborer	H
113	Broker	
Building and Construction		
209	Wrecker, Driller, Rigger, Mover	H
210	Contractor (office duties only)	
211	Shorer, Electrician under 250 volts	S
212	Electrician (over 250)	H
213	Bulldozer Operator, construction only	S
214	Bulldozer Operator, logging	H
521	Burners, metal industry	H
345	Busboy	S
151	Bus Driver	S
215	Butcher	S
Buyer		
079	Cotton, fur, grain, produce, wool, etc.	S
109	Retail Store	P
143	Builder	S
201	Cabinetmaker	S
179	Cabin Camp (Operator or Worker)	S
180	Caretaker	S
201	Carpenter	S
107	Cashier—Bank	P
215	Caterer	S
117	Cattleman	S
204	Cement and Concrete Finisher	S
192	Chainman, Rodman, Axman	S
018	Chaplain—see Clergymen	P
151	Chauffeur and Driver	S
246	Chef (Head Chef only)	S
Chemical Industry		
081	Chemist, analytical or lab work only	S
216	Skilled Automatic Process Operator	S
082	Chemist, consulting, no lab or plant work	P
217	Office Personnel	P
218	Machine Operator, Maintenance Man, Still and Tank Cleaner	H
219	Acid Handler	H
123	Chicken or Poultry Raiser (see Farm and Ranch)	S
521	Chippers (Metal Industry)	H
019	Chiropodist	P
020	Chiropractor	P
220	Cigar or Cigarette Maker	S
221	Circus Worker	N
222	Citrus Fruit Industry (all classifications)	S
021	Civil Engineer	S
223	Claim Agent, Adjuster	P
224	Cleaner and Laundry (all classifications)	S
018	Clergymen	
109	Clerk	P
225	Clock, Watchmaker, repair	S
226	Clothing Manufacture Employee	S
029	Coach, Professional (Head Coach only)	S
030	Coach, University (Head Coach only)	S
237	Cobbler	S

Coke Ovens

238 Foreman and Skilled Worker-----	S
29 Nonskilled Worker-----	S20

112 Collection, Bills and Accounts-----	P
076 Columnist-----	P
121 Combine Operator (minimum employment 9 months out of 12)-----	S
240 Commercial Artist-----	P
346 Commission man (livestock)-----	S
204 Concrete and Cement Workers-----	S

Conductors

241 Passenger-----	S
242 Freight and Mixed-----	H

Construction

243 Road, Street, Sewer (except tunnel)-----	S
244 Metal Tank-----	H
245 Tunnel or under compressed air (shaft or subway)-----	N
053 Contractor (office or supervisor duties only)-----	P
246 Cooks-----	S
515 Coopers-----	S
048 Copilot scheduled airline-----	S

Cotton Gin

084 Proprietor Manager (superintending duties only)-----	S
247 Foreman and other Employees-----	N
248 Counselor-----	P
249 Crane Operator, Manufacture-----	S
250 Credit Analyst or Reporter-----	P
251 Creamery and Dairy Plant Workers-----	S
325 Crewmen, oceangoing vessels (see Marine Industry)-----	H
326 Crewmen, other vessels—not fishing (see Marine Industry)-----	S
085 Cryptanalyst-----	P
085 Cryptographer-----	S
180 Custodian-----	S
167 Customs Inspector-----	S
118 Dairyman, Dairy Worker, Farmer-----	S
378 Data Processing Programmer-----	P
379 Data Processing Machine Operator-----	P
344 Dancing Instructor, Entertainer-----	S
152 Decorator, Interior-----	S
153 Deliveryman-----	S
033 Dentist, Assistant, Hygienist-----	P
313 Dental Technician—Laboratory Assistant-----	S
028 Dermatologist-----	P
253 Derrickman, Builder-----	S
254 Designer-----	P
168 Detective-----	S
256 Diamond Cutter-----	S
255 Die Caster, Maker, Sinker, Polisher-----	S
086 Dietician or Nutritionist-----	S
257 Dispatcher (Taxicab)-----	S
258 Distillery, Alcohol-----	S
259 Diver-----	N
260 Dock Worker-----	S

Doctor—See Specific Title

154 Doorman-----	S
261 Draftsman-----	P
262 Dressmaker-----	S
263 Driller (mining—oil field—construction)-----	H
264 Driver (Racing)-----	N
155 Ash, garbage, logging-----	H
151 Others-----	S
087 Druggist-----	P
265 Dye Worker-----	S
076 Editor-----	P

516	Egg Grader, Packer, Candier, etc.....	S
212	Electrical, handling live wires, Tower Erectors.....	H
212	Electrician Lineman, Cable Splicer, Troublemán, Tunnel Worker.....	H
211	Electrician	S
266	Electronics Technician.....	S
267	Electroplater	S
156	Elevator Operator.....	S
268	Elevator Builder or Repairer.....	H
269	Embalmer	S
270	Enameling, Burner, Smelterman, Sprayer, Laborer, Mixer.....	H
271	Enameling (others).....	S
021	Engineer (office duties).....	P
022	Engineer, others (nonhazardous).....	S
272	Engineer—Railroad	S
267	Engraver	S
273	Essayer	S
267	Etcher	S
Explosive Manufacture		
274	Plant and Production Worker (no accidental death).....	S
275	Office Worker, one-half mile from plant.....	P
276	Guard	S
Exterminators—see Fumigator		
119	Farm Agent.....	S
120	Farm Implement Dealer.....	S
121	Farmer (all types usually, Farmhand).....	S
377	Farm Manager, Office Duties Only.....	P
254	Fashion Designer.....	P
169	F.B.I. Agent.....	S
277	Feed Grinder, Miller, or Mixer.....	S
278	Fertilizer Manufacture Worker.....	S
109	File Clerk.....	P
521	Filers, (Metal Industry).....	H
291	Filling Station Proprietor and Worker.....	S
280	Film Manufacture Worker.....	S
Fireman		
170	Fire Department (metropolitan—individual consideration).....	--
281	Railroad	S
282	Stationary	S
171	Fish and Game (Warden).....	S
126	Fishing Industry (curing and packing).....	S
Fisherman		
127	Boats of 85 ft. in length or over and coming ashore daily.....	S
128	All others which include grand banks, sealers and whalers.....	H
283	Floor Finisher or Sander.....	S
284	Florist	S
277	Flour, Grain Mill—Elevator Worker.....	S
029	Professional Football Head Coach.....	S
030	Football University Head Coach.....	S
009	Football Player.....	N
222	Food Canning and Preserving Worker.....	S
132	Forestry, Manager only.....	P
Foreman—see specific industry or classification		
130	Forester, Field Worker.....	S
131	Forest Ranger.....	S
294	Foundry Worker, No Pouring or Melting.....	S
347	Freight Handler, Checker.....	S
222	Fruit Grader or Packer, Grower.....	S
285	Fumigator (works with cyanide gas).....	H
286	Fumigator (handles hydrocyanic acid or its derivatives).....	S
269	Funeral Attendant or Director with embalming.....	S
088	Funeral Attendant or Director—no embalming.....	P
122	Fur Breeder.....	S
287	Fur Goods Preparation—Manufacture Worker.....	S
288	Furnace, Repair Man or Installer.....	S

Foreman—see specific industry or classification—Continued

201	Furniture, Woodworker	S
289	Galvanizer and Tinner	S
290	Gambler (professional)	N
171	Game Warden	S
291	Garageman—Mechanic	S
155	Garbage Man, Collector	H
292	Gardener	S
293	Gas Bottler	H
153	Gas Deliveryman	S
291	Gasoline Station Employee	S
294	Gear Manufacture Employee	S
256	Gem Cutter	S
024	Geologist	S
295	Glass Products Worker	S
296	Glazier	S
297	Glucose Manufacture Worker	S
298	Goldsmith	S
011	Golfer (professional)	S
213	Grader Operator (road construction)	S
277	Grain Worker—Elevator Operator, Shoveler, Loader	S
299	Granite Worker (Polisher and Cutter)	S
300	Graphite Employee	S
301	Gravel Pit Worker	S
292	Greenhouse Worker	S
114	Grocery Store, Checker	S
292	Grounds Keeper	S
166	Guard	S
157	Guide (hunting—fishing)	H
158	Guide (mountain climbing)	N
302	Gunsmith	S
303	Gypsum Worker	S
199	Hairdresser or Stylist	S
121	Harvesting Hand, all types	S
129	Hatcheryman, Fish	S
123	Hatcheryman, Poultry	S
288	Heating Installer	S
079	Hide Dealer	S
365	Hide Handler	S
243	Highway Construction and Maintenance	S
089	Historian	P
013	Hockey Player	N
374	Hotel-Motel Manager (supervisory)	P
143	Housekeeper	S
517	Hydrotherapist—see Physical Therapist	S
251	Ice Cream Manufacture Plant Worker	S
304	Iceman, Plant Worker	S
167	Immigration Inspector or Officer	S
305	Insecticides Manufacture Worker	H
172	Inspector (Police)	S
306	Inspector—manufacturing and processing	S
090	Instructor	S
091	Insurance Agent, Broker	P
152	Interior Decorator	S
307	Inventor	S
173	Investigator	P
180	Janitor	S
308	Jeweler, Manufacture	S
012	Jockey	N
076	Journalist	P
026	Judge	P
144	Kennelman	S
521	Kettleman—smelting and refining	H
310	Keymaker (inside worker only)	S
110	Keypuncher	P

311	Kiln Worker	S
246	Kitchen Worker	S
226	Knitter	S
312	Laboratory Worker	S
313	Laboratory Technician and Assistant	S
314	Laborer, general	S
314	Labor Union Worker	S
178	Landlady	S
178	Landlord	S
292	Landscape Gardener	S
292	Landscaper	S
224	Laundry Worker	S
025	Lawyer	P
315	Leather Manufacture	S
316	Lens Grinder	S
092	Librarian	P
317	Lighthouse Keeper	S
318	Lifeguard	S
301	Lime Mining Worker	S
212	Lineman	H
319	Linoleum Worker	S
093	Liquor Manufacture Industry (office duties only)	P
258	Liquor Industry (all others)	S
320	Lithographer	S
117	Livestock Feeder, Rancher, Salesman, Auctioneer, Livestock	S
321	Locksmith	S
260	Longshoreman	S
366	Longshoreman (supervisory only)	S

Lumber Industry

133	Logging	H
134	Blasting	N
135	Camp Crew	S
214	Tractor and Truck Driver	H
136	Contractor (office only)	P
137	Contractor (supervisory)	S
138	Driver	H

Pine Lumber Operation Only

139	Logger	S 20
140	Supervisor	S
141	Driver	S 20
379	Machine Operator, Data Processing	P
255	Machinist, Machine Shop Worker	S
322	Magnesium Industry Worker	S
143	Maid	S
323	Mail Carrier and Clerk	P
054	Manager, Office Duties	P
631	Manager, Farm	S
324	Manicurist	S

Marine Industry

325	Crewman (freighters and oilers)	H
326	Crewman (passenger liners)	S
055	Captain and Officer (ocean-going vessels)	S
056	Captain and Officer (other vessels)	S
204	Mason	S
327	Masseur	S
328	Meat Packing and Processing	S
291	Mechanic	S
028	Medical Doctor	P
313	Medical Technician	P
160	Messenger	S

Metal Industry

329	Metal Industry Workers	S
522	Manual pouring or melting	H

Metal Industry—Continued

521	Burners, filers, chippers-----	H
043	Metallurgist -----	S
094	Meteorologist -----	P
251	Milk Plant Worker (Milkman, Dairyman, etc.)-----	S
277	Miller -----	S
201	Millwright -----	S
330	Mine Inspector-----	S

Mining, Quarrying, Ore Dressing and Concentrating

Hydraulic, dredge and other placer mining, open pit and strip mines, sand and gravel quarries, clay pits.

Stone quarries, granite, sandstone, limestone, marble, asbestos and slate:

331	Blaster and Explosive-----	N
332	Foreman -----	S
333	Worker (mine only)-----	S

Asbestos Mill Reduction

334	Worker -----	H
335	Foreman -----	S

Zinc, Lead and Manganese—Other Mills

336	Foreman -----	S
337	Skilled Worker (Tableman, Vannerman, Jiggerman, Tank Operator) -----	S
338	Worker around Crushers and Stamps-----	H

Underground Mines

339	Surface Worker-----	S
400	Underground Worker—rate will depend upon class of mine, product, section of country and location of mine.	
095	Mineralogist -----	S
018	Minister -----	S
295	Mirror Maker-----	S
521	Molder -----	H
374	Motel—Hotel Manager (supervisory)-----	P
402	Monument Worker—Carver, etc-----	S
269	Mortician—see Funeral Director-----	S
179	Motel Operator-----	S
291	Motor Assembly Worker-----	S
151	Motorman -----	S
403	Mover -----	S
404	Movie Production Worker-----	S

Munitions Worker—see Explosive Manufacture

381	Musician—hotel, theater, restaurant—concert—symphony, 1st class--	P
405	Musicians, other-----	S
406	Neon Signmaker and Serviceman-----	S
028	Neurologist -----	P
407	Newspaper Advertising-----	P
408	Newsboy -----	S

Nitroglycerin Makers, Handlers, Users—see Explosive Manufacture

076	Novelist -----	P
371	Nurse -----	S
370	Nurse—Receptionist, clerical duties only-----	P
372	Nurses Aid-----	S
292	Nurseryman -----	S
226	Nylon Manufacture Worker-----	S
028	Obstetrician -----	P
032	Oculist -----	P
057	Office Manager-----	P
109	Office Clerk-----	P
115	Office Machine Salesman-----	P
411	Office Machine Serviceman-----	S
412	Oilcloth Manufacture-----	S
058	Oil Distributor, Office Only-----	P

263	Oil Driller	H
413	Oil Blender and Mixer, Refiner	S
032	Optician	P
032	Optometrist	P
121	Orchardist	S
033	Orthodontist	P
034	Osteopath	P
328	Packhouse Worker	S
348	Packer	S
414	Painter (building and structural steel)	H
415	Painter (Steeplejack)	N
416	Painter (other)	S
417	Paint Maker, Manufacture	S
418	Paper Products Maker	S
Paper and Pulp Mills		
419	Pondman, Slipman, Log Pile Worker and Laborer	S 20
420	Others	S
292	Park Caretaker	S
161	Parking Attendant	S
018	Pastor	P
028	Pathologist	P
340	Pawnbroker	S
421	Performer, Entertainer	S
422	Personnel Worker	P
Petroleum Worker		
423	Acid Recovery, Separator and Concentrator Workers	H
413	Others	S
057	Pharmacist	P
114	Pharmacy Employee (sales only)	P
424	Photograph Manufacture Worker	P
267	Photoengraver	S
Photographer		
096	Aerial	N
097	Commercial	S
098	Motion Picture	S
099	Studio	P
028	Physician	P
517	Physical Therapist	S
036	Physicist	P
Pilot—see Aviation Industry		
425	Pipeline Worker	S
426	Plasterer	S
427	Plumber	S
174	Police Officer, Guard	S
380	Police Officer, Motorcycle Man	H
148	Porter	S
Postal Worker		
323	No Driving, (clerical duties only)	P
151	Postal Driver or Carrier	S
222	Potato Chip Maker	S
429	Pottery Maker	S
123	Poultryman—Grower, Feeder, Grader, Dresser	S
430	Powerman	H
372	Practical Nurse	S
018	Preacher	P
222	Pretzel Maker	S
018	Priest	P
320	Printer	S
342	Professor	P
378	Programmer, Data Processing	P
044	Psychologist—Psychiatrist	P
076	Publisher	P
433	Putty Manufacture	S
333	Quarryman, Worker (no explosives)	S

018	Rabbi	P
434	Radio Announcer, Engineer	P
435	Radio Repairman, Mechanic	S
436	Radio Manufacture Worker	S
027	Radiologist	P
437	Radium Worker	N
Railroad		
059	Announcer, Information Bureau, Telephone Operator, Station Agent	P
438	Trainmen, freight and mixed; yard except engineer	H
272	Engineer	S
281	Trainman, passenger	S
	Conductors—See Conductors	
117	Rancher	S
226	Rayon Manufacturer Plant Worker	S
070	Real Estate Agent	P
370	Receptionist	P
031	Referee—Umpire	S
Refinery Worker		
440	Acid Recovery, Separator and Concentrator	H
441	Others	S
442	Refrigerator Worker (plant), Installer	S
443	Rendering Plant Worker	S
201	Repairman, Mechanic	S
076	Reporter	P
021	Research Engineer	P
181	Resort Operator	S
182	Restaurant Operator (supervisory only)	P
018	Reverend	P
202	Rigger	H
243	Road Builder or Construction Worker	S
454	Rock Breaker or Driller	H
444	Rodeo Performer	N
192	Rodman, Axman, Chainman (surveying)	S
027	Roentgenologist	P
445	Rolling Mill Operator	S
446	Roofer	S
447	Roofing Material Manufacture Worker	S
448	Rone Maker	S
449	Rubber Maker	S
450	Rug and Carpet Maker	S
451	Sacker (grain, feed, flour, sugar, lime, etc.)	S
315	Saddle Maker	S
114	Salesman (no delivery)	P
114	Sales Clerk	P
452	Salt Worker (refineries, surface workings)	S
453	Sandblaster	H
301	Sand and Gravel Worker	S
Sawmill Worker		
455	Car Loader	S 10
456	Carriage Rider	S 10
457	Chute Man	S 10
458	Crane Hooker	S 10
459	Lath Machine Operator	S 10
460	Large Mills—Log Canter, Deckman or Jacker	S 10
461	Small Mills—Log Canter, Deckman or Jacker	S 20
462	Lumber Carriage Operator	S 10
463	Off Bearers, head rig only	S 10
464	Off Bearers, others	S
465	Pondman, Slipman, Boom Man	S 20
466	Ratchet Setter, Hand or Dogger	S 20
467	Ratchet Setter, machine	S 10
468	Sawyer (no automatic guard)	S 20
469	Shingle Bolter or Sawyer	S 10
470	Slasher Machine Operator	S 10

Saw Mill Worker—Continued

471	Stripper Lath Mill	S 10
472	Other classifications in mills and machine operator (non-hazardous)	S
473	Scrap Metal Dealer	S
024	Scientist	P
101	Sculptor	S
262	Seamstress	S

Seaman—see Marine Industry

474	Seasonal Worker (must have minimum of 9 months' employment)	S
110	Secretary	P
143	Servant	S
475	Serviceman (telephone, etc.)	S
291	Service Station Worker	S
476	Sewage Disposal Worker	S
243	Sewer Construction Worker (except tunnel construction)	S
117	Sheep Rancher	S
255	Sheet Metal Worker	S

Ship and Boat Building Worker—see Boat and Ship Building

Shipping—see Marine Industry

315	Shoe Manufacture Worker (repair)	S
477	Sign Maker, Erector, Painter	S
478	Sign Designer, Writer	P
298	Silversmith—Silverware Manufacture Worker	S
405	Singer—Entertainer	S
479	Skater, professional	N
480	Skier, professional	N
481	Ski Manufacture Worker	S
328	Slaughterhouse Worker	S
294	Smelter Worker	S
482	Soap Manufacture Worker	S
102	Social Worker	P
103	Solicitor	P
483	Song Writer	P
484	Stableman	S
282	Stationary Engineer	S
203	Steamfitter	S
110	Stenographer	P
260	Stevedore	S
366	Stevedore (supervisory only)	S
485	Steward	S
206	Steelworker (construction)	H

Steelworker—(steel manufacture)—see Metal Industry Worker

486	Steeplejack	H
117	Stock Raiser, Grower or Feeder	S
113	Stock and Bond Salesman	P
487	Stock and Supply Clerk	S
488	Stockyards Worker	S
402	Stone Worker	S
114	Store Buyer, Clerk, Owner, etc. Cashier	P
349	Street Cleaner	S
489	Studio Technician, Engineer	S
375	Stunt Man	N
222	Sugar Refinery Worker	S

Superintendent

060	Office duties	P
061	Production or outside duties	S
028	Surgeon, Physician	P
062	Surveyor	S
262	Tailor—Tailoress	S
315	Tannery Worker	S
195	Tavern Operator	S
104	Tax Collector	P
151	Taxi Driver	S

105	Taxidermist -----	S
342	Teacher -----	P
376	Teacher—Vocational -----	S
490	Telegrapher -----	P
475	Telegraph or Telephone Equipment Worker, Repairman, (no Line- man) -----	S
490	Telegraph or Telephone Operator -----	P
107	Teller or Cashier -----	P
435	Television Service and Repair -----	S
014	Tennis Player -----	S
191	Tent Maker, Canvas -----	S
226	Textile Manufacture Worker -----	S
063	Theater Manager -----	P
	Theatrical Performer (see actor or actress)	
040	Therapist -----	S
341	Ticket Agent -----	P
429	Tile Manufacture Worker -----	S
	Timberman—see Lumber	
111	Timekeeper -----	P
255	Tinsmith -----	S
449	Tire Manufacture Worker -----	S
220	Tobacco Products Manufacture -----	S
124	Tobacco Farmer -----	S
255	Toolmaker -----	S
179	Tourist Camp, Motel Owner, Employee, Attendant -----	S
255	Toy Maker -----	S
	Track Worker (Railroad—See Railroads)	
	Train Worker—see Railroads	
	Trainer, Animal—See Animal Trainer	
491	Trainer, Athletics -----	S
492	Trapper -----	S
155	Trash Collector -----	H
341	Travel Bureau Worker -----	P
413	Treating Plant Worker (oil) -----	S
493	Tree Trimmer, Surgeon -----	S
125	Truck Farmer -----	S
163	Tuning Piano -----	P
	Tunnel Construction Worker—see Construction	
494	Turbine Operator (electricity) -----	S
495	Turpentine Plant Worker -----	S
320	Typesetter -----	S
411	Typewriter Repairman -----	S
110	Typist -----	P
031	Umpire -----	S
	Underground Worker—see Occupation	
269	Undertaker—with embalming -----	S
088	Undertaker—no embalming -----	P
496	Union Representative -----	S
497	Upholsterer -----	S
164	Usher -----	S
143	Valet -----	S
417	Varnish Manufacture -----	S
	Vaudeville Performer—see Actor or Actress	
222	Vegetable Canner -----	S
165	Vendor -----	S
	Vermis Exterminator—see Fumigator	
041	Veterinarian -----	S
498	Violin Maker -----	S
499	Waiter -----	S
499	Waitress -----	S
175	Warden -----	S

403	Warehouseman -----	S
225	Watchmaker -----	S
176	Watchman -----	S
094	Weatherman -----	P
500	Welder -----	S
102	Welfare Worker -----	P
263	Well Digger or Repairman, oil—see oil well -----	H
501	Well Driller, Puller (water) -----	S
260	Wharfman -----	S
White Lead Manufacture Plant Worker		
502	Foreman (supervisory only) -----	S
503	Production Worker -----	H
504	Wig Maker -----	S
145	Wild Animal Trainer -----	N
505	Winchman -----	S
506	Wind Instrument Maker or Repairman -----	S
507	Windmill Manufacturer -----	S
508	Windmill Repairman -----	S
509	Window Cleaner -----	H
510	Window Dresser -----	S
511	Wire Maker -----	S
201	Woodworker -----	S
201	Wood Products Manufacture Worker -----	S
Wood Pulp Worker—see Saw Mill		
226	Woolen Mill Worker -----	S
226	Wool Sorter or Grader -----	S
015	Wrestler -----	N
076	Writer -----	P
373	X-Ray Technician -----	S
512	X-Ray Repairman, Tester, Salesman -----	S
226	Yarn Maker, Worker, Dyer -----	S
336	Zinc, Lead and Manganese—other mills, Foreman -----	S
337	Zinc, Lead and Manganese—other mills, Skilled Worker -----	S
338	Zinc, Lead and Manganese—other mills, Worker around crushers and stamps -----	H
106	Zoologist (teaching only) -----	P
390	Zoologist, Field Worker -----	S
513	Zoo Worker -----	S

[Reprint from May 8, 1967, issue authorized by the AMA News]

INSURANCE FORMS

It is the policy of the American Medical Association that attending physicians should complete "simplified" health insurance forms, without charge, as a part of the physician's service to the patient.

Both the patient and the physician benefit when the patient has voluntary health insurance and the assistance the MD can give the patient to collect his benefits is a natural part of the physician-patient relationship. Many health insurance companies use the "simplified" claims form developed by AMA's Council on Medical Service and the Health Insurance Council.

AMA's Judicial Council, in response to recurring questions, adopted this statement in 1965 in conformity with a resolution adopted by the House of Delegates in 1961:

"The attending physician should complete the appropriate 'simplified' Health Insurance Council forms approved by the Council on Medical Service, without charge, as a part of the physician's service to the patient to enable him to receive his benefits.

"The Judicial Council is of the opinion that it is implicit in this statement of the House of Delegates that a charge for more complex forms could be made in conformity with local custom.

"This suggestion is advisory. In all cases, the local medical society can be looked to for an authoritative opinion."

Most physicians do help their patients by filling out insurance claim forms. Those who do not or who grumble about the trouble might consider this statement from a letter from a patient in Iowa: "We accept the fact this takes a little

of (the doctors') time and at the same time we can say that if we did not have the insurance we might not have been their patient."

The House of Delegates has noted that the preservation of the American system of private practice of medicine may well depend on the success or failure of voluntary health insurance financing health care costs. One way physicians can help assure the success of such insurance is to help patients with their claims forms.

DOCTOR'S CHARGES FOR BENEFITS FORM COMPLETION—NOVEMBER 15, 1967

Here is a reprint of an editorial from the AMA News for your use if either a policyowner complains that he has been charged a fee by his doctor, or a doctor charges your office for the completion of our usual benefits form. It should be valuable in amicably resolving any misunderstanding which may arise in this area.

Our Company was permitted to make and use the reprint with the agreement that it must not be a part of advertising material and with relation to only a charge by a doctor for completion of our usual benefits form. Strict compliance with these conditions is mandatory. As you know, it is our Company's practice to remit the customary doctor's fee when a special medical report is requested either by us or in our behalf by an inspection agency.

The following is a suggested transmittal letter to accompany the reprint if the complaint is made by the policyowner who requests refund of his payment of a doctor's fee for completion of the form:

Dear Policyowner (by name):

Thank you for your letter about the charge Dr. _____ made for completion of your application for benefits form.

Enclosed is a reprint of an editorial concerning this matter which our Company has been authorized to furnish to you. It contains the official policy of the American Medical Association. We hope it will be helpful for cordial relations between you and your doctor concerning the removal of the charge which you have reported to us.

Sincerely,

MUTUAL OF OMAHA—INDIVIDUAL CLAIMS PROCEDURAL MANUAL—PART I

If the complaint is made to you by the doctor who bills you or informs you that the form our policyowner has furnished to him will be completed upon remittance, this transmittal letter is suggested:

Dear Dr. _____:

Your statement (or letter) concerning a charge for completion of our benefits form for your patient and our policyowner, _____, was unexpected.

Enclosed is a reprint of an editorial from the American Medical Association News which our Company was authorized to make and use in this situation. It is our Company's practice to remit the customary fee when a special medical report is requested from a doctor. Otherwise, we are guided by the contents of the enclosed reprint.

You are assured that we appreciate your cooperation in completing the benefits form which was approved by the American Medical Association's Council on Medical Service and the Health Insurance Council.

Sincerely,

R. L. MCGARGILL, *Vice President.*

FRANCHISE GROUP CONTRACTS—UNDERWRITING

This shows categories company finds unacceptable as good risks for franchise group contracts. Under franchise arrangements, group members are subject to the same underwriting requirements as if they were issued individual contracts. Franchise is not true group and is more of a marketing gimmick than group coverage.

* * * * *

3.4 Other Mutual policies, such as the Good Neighbor series, cannot be written in the same group with special Franchise plans, except in certain special cases, where arrangements are made prior to solicitation of the group. Any individual plans authorized should be coded PRD or SCF for group identification.

3.5 Special supplemental coverage riders have been designed for these plans, and other individual type riders may not be used.

4. Participation

There is no required participation, other than the necessary minimums, on PRD and SCF groups except in New York; however, to insure the successful continuance of the group, maximum participation must be maintained. Regular callbacks and contacts with new employees or members will help accomplish this. (See requirements for nonselective underwriting.)

Any groups dropping below the minimums (PRD-5; SCF-10) will be subject to cancellation if minimum strength is not soon achieved. Statutory requirements must be maintained.

5. General occupational qualifications

5.1 Because of the special features of these plans, certain industries may not qualify. No applications should be taken on the following type groups until cleared by the Home Office:

- (1) Junk dealers or scavengers.
- (2) Logging or sawmill operations.
- (3) Slaughter houses, tanneries or rendering plants.
- (4) Mines and stone quarries.
- (5) Lower class bars and restaurants. (Class A establishments with low employee turnover may be considered but only after a statement fully describing the operation with employee turnover figures has been approved by the Franchise Division. Do not submit applications with the statement.)
- (6) Hospitals. (City, county or state hospitals are acceptable on disability and hospitalization provided employees cannot use the facilities. Other hospitals are acceptable on disability only.)
- (7) Rest and nursing homes.
- (8) Church congregations (some insurance departments may not recognize as a qualifying group).
- (9) Members of the clergy or religious order (these groups may qualify for special type blanket coverages in some states).
- (10) Any organization which is seasonal or has a high employee turnover will not qualify—APPLICATIONS SUBMITTED FOR GROUPS WHICH DO NOT QUALIFY WILL BE RETURNED.

6. Requirements for "nonselective" underwriting

6.1 Participation Requirements: (Special minimum for Colorado and North Carolina.)

Right of selection on health can be waived if participation requirements are met, but in both PRD and SCF groups, the Franchise Division reserves the right to reject the group (as a whole) or underwrite it on a selective basis if there is an excessive number of seriously impaired risks.

Total employees/members: (under age 64)

Number of qualified risks:

5 through 10	100 percent of total
11 through 14	100 percent of total less 2
15 through 19	100 percent of total less 3
20 through 24	100 percent of total less 4
25 through 49*	80 percent of total
50 through 74	70 percent of total
75 through 99	60 percent of total
100 or more	50 percent of total

*SCF groups with fewer than 25 members or employees must always be processed on a selective basis.

6.2 Dependents: 80% of eligible dependents must apply.

6.3 NOTE.—(a) If "no selection" is desired on hospital coverage (121H/HF), the above-required percentage (of those under age 64) *must all apply for a hospital plan*. A "hospital plan" may include a 2716M rider attached to a 121DL-122DL to satisfy the quota.

(b) If "no selection" is desired on disability coverage (121DL-122DL), the above-required percentage (of those under age 64) *must all apply for a disability plan*.

(c) *Unimpaired applicants* may choose any plan or benefit (121DL-122DL-121H/HF) within the regular maximum limits of the Company.

MUTUAL OF OMAHA—INDIVIDUAL CLAIMS PROCEDURAL MANUAL—PART I

Here is another indication of company's sensitivity about background information it collects. The statement by Retail Credit Company about not giving the impression that acceptance or rejection relied solely on the results of the investigation should be checked with the requirements of the Fair Credit Reporting Act.

* * * * *

CONFIDENTIAL INFORMATION—NOVEMBER 15, 1967

Libel and slander, in essence, involve any written or spoken utterance of a person which defames or injures the character or reputation of another. This may come about through the release of personal or confidential information concerning a policyowner. Often it will result in legal action against the Company, the investigating agency which may have secured the information, and the individual who released the information. Always it involves breach of good faith.

Recent trends in legal decisions have not been favorable to defendants. This makes it imperative that anyone entrusted with personal or confidential information check to be certain such is properly protected.

Benefits requests always involve facts that are personal and therefore confidential. It is proper that these facts be used in benefits administration. It follows that these facts should be *known only to those persons* who need them for their work. The factual information is furnished on the understanding it will be used in confidence. Without this understanding, the source of the information may be closed.

Occasionally, others in the Company are given confidential information that is not necessary to their purpose. Thus, directly or indirectly, the confidential information may come back to the person it involves. This results in bad feelings and often in libel suits against *all* who may be involved. Any publication to persons who do not have to know destroys the qualified privilege which gives some protection in many jurisdictions.

Remember, inspection report information is largely what people say about the subject. Inspectors and their sources of information are human. While most are accurate, errors can occur. Even the truth cannot always be proved in court since the informant may be reluctant to testify.

New employees should be trained in the necessity of protecting confidential information and the consequences of the unauthorized release of same. Experienced employees should be briefed periodically on the confidential nature of inspection reports or other information in file. Enclosed is a folder prepared by Retail Credit which stresses the importance of protecting inspection reports. The comments therein apply to any confidential information.

R. L. MCGARGILL, *Vice President*.

CONFIDENTIAL HANDLING—HOW AND WHY

The need for information in passing on business transactions is recognized by the legal principle of "privileged communications." However, the law requires limited use and confidential handling:

Reports should be accessible only to those who must see them for passing on the transactions to which they relate.

Never reveal information in Reports to third parties including agents, salesmen, or others who may initiate transactions on which Reports are obtained. You can be sued as the publishers of the information.

Never request a Report for a third party as an accommodation. The law affords no protection.

Serious embarrassment and expense can result if subjects of Reports become aware of the facts in the Reports or of the source. To prevent this, take the following precautions:

Never give to persons on whom Reports will be obtained the impression that their selection or rejection will be based solely on the result of investigation. It is, however, satisfactory to tell insurance applicants that an investigation will be made. In the case of applicants for employment or for selection as agents, it is best to say nothing about an investigation. Inspection Reports merely supply information. The selection or other action is taken by those who use Reports.

When the subject of a Report is or will be in your office. Reports should be under cover. Never talk to the subject with Report in hand.

Never give to subjects on whom action has been taken any impression that the action was influenced by Report information.

Protection of Sources

The intimate information in reports is given to us in confidence. Any embarrassment of sources as a result of improper handling of reports immediately restricts availability of the facts needed.

Police record information should be especially protected to preserve availability of this important source of confidential records.

Accuracy of Information

Since reports are made by and through fallible human sources, the accuracy or completeness of information cannot be guaranteed. However, as determined by our continuous reviews, a high degree of accuracy is achieved in our reports.

Agreement For Service

The legal hazards connected with reports, and the methods of obtaining information, explain a portion of the wording in our Agreement for Service:

"All reports, whether oral or written, will be kept strictly confidential; no information from reports nor your identity as the reporting agency will be revealed to the person reported on or to any other person except a person whose duty requires him to pass on the transaction in relation to which the report was ordered. No information will be requested for the use of any other person except with your written permission. . . . We agree that the accuracy of information is not guaranteed by you . . ."

Careful observation of these precautions and the cooperation of users of the service will result in mutual protection from litigation, and will help to keep open valuable sources of needed facts.

RETAIL CREDIT COMPANY.

MUTUAL OF OMAHA—INDIVIDUAL CLAIMS PROCEDURAL MANUAL—PART I

This discloses company's position in supplying information to other insurers in avoidance of violation of Sherman Antitrust law.

INQUIRIES FROM OTHER INSURERS—MAY 1, 1970

We have received a number of questions relative to the information which should be furnished on inquiries from other insurers. While we do want to maintain close cooperation with other insurance companies in this important function, care must be exercised to be certain any information which we provide is not in violation of the Sherman Antitrust Law. With this in mind and from a legal standpoint, the following rules were developed . . .

1. Claims personnel sending written responses to inquiries from other insurance companies concerning our policyowners' claims records should divulge only: (1) the benefits provided by the policy and (2) the amount of benefits paid (itemization of the benefits paid, when requested, is permissible). Do not reveal adverse actions such as rescission or rejections.

2. The names of physicians, hospital, the diagnosis, date of treatments, etc., can also be disclosed.

3. The results of independent investigations can be revealed but not the source (e.g., Retail Credit Company, I.S.B., etc.).

4. Claims adjustors should not work with an adjustor from another insurance company in taking final action on a claim.

5. It is permissible for our Company to join with other companies in sharing the expenses of investigations, physical examinations, etc. However, we cannot participate in any session that could be construed as a joint action in reaching a final decision as to the merits of the claims.

6. A personal review of our file can be granted to an authorized representative of another company. The consideration for this review is based on not disclosing the source of his findings and that our file must be subpoenaed if it is necessary to prove a point in a legal contest.

7. Information furnished, other than on benefits paid, should be restricted to items concerning Mutual individual coverage. Requests for information on coverage other than Mutual individual (excluding Group) should be referred to the Home Office.

Most Group insurance contracts contain a nonduplication clause. This clause states, in effect, that the payment of benefits under a combination of Group coverages will not exceed the total expense incurred. In order to coordinate the payment of benefits, Group carriers use a standard inquiry form to exchange information. The items requested by this form are in agreement with the Anti-trust Law. Since the nonduplication of benefits involves only Group coverages, these inquiries should be referred to the Group office in your area.

R. C. ELLIS.

Vice President, Claims Division.

Senator HART. We welcome you, Mrs. Hentges. Please proceed.

STATEMENT OF MRS. JUDITH HENTGES

Mrs. HENTGES. My name is Judith Hentges. I live at 2639 Dove Street in Dubuque, Iowa. I'm employed at the National Tea Co., and have worked there for 8 years under a union contract negotiated by the Retail Clerks' Union Local 396 in Dubuque.

I mention the union because it has had a very important impact on my life. If it had not been for my union's health and welfare program, my family would have faced certain economic disaster.

My late husband came down with cancer 12 years ago, just after the birth of our first child. I don't really want to live through all these horrible details again. Just let me say my husband had 25 percent of his body amputated before he passed away last August, after more than 11 years of total disability.

But coupled with his problem is the fact that my first baby developed hearing difficulty which has resulted in six major surgeries and constant attention from the doctors.

He also has been down with such things as measles, meningitis, scarlet fever, and an almost incredible number of other ailments.

The records of the union negotiator's health and welfare programs show some interesting figures for me and my family.

Since August of 1968, the program has paid us a total of \$13,202.26 in claims. These records show that there was a total of \$2,526 which we filed for, but was disallowed under the terms of the program. And it is a very good program by all the standards that I know.

It pays far, far more than what many of our friends receive. And I shutter to think where I would have been if I had been working in a nonunion store in Iowa, where health and welfare programs are practically nonexistent.

So, we had to pay out \$2,526 from our own pocket, and it just wasn't there. I remember my husband, Alan, being upset because we couldn't seem to make out on his total disability payments through social security plus what I was making.

The fact is that we sat down and figured it out. At that point I added up all our bills for the year—gas, lights, rent, all the rest. Everything except food. And we had spent \$6,700. But our total income was only \$7,200 for the year.

That's because I had to take time off from work to be with Alan while he was hospitalized for long periods of time at Iowa State Hospital, some 90 miles from our home.

There were other expenses you couldn't begin to count, gas for the car, food for me while I was at the hospital, dental and optical bills, special costs for all kinds of emergencies.

Imagine we were trying to take care of my ill husband, four children and my sister, who lives with us so she can babysit the children while I work. That's seven people on \$7,200. We just could not make out.

And it was even worse when we had to go on welfare when Alan first became ill. I wish I could communicate to you gentlemen the terrible misery that effects so many working people like myself.

There is real pain when you have to ask your parents to mortgage their home to bail you out and put food on your table. There is a terrible sense of hopelessness and monotony when you have to go down to the credit union for another loan, then another, and then a loan to lump all these loans together and stretch it out so the payments don't hurt so much.

My husband was ill, but that made him no less a man. He had to sit there and not show the hurt when the bowling leagues took up a collection on our behalf and when the gift shop circle at the hospital paid a hospital bill off for us.

There were relatives and friends who came by with money, loaned it or outright gave it. There was so much physical and emotional misery in our family that my husband, himself, suffered from a gastric ulcer before he died.

The strain has told on me too because I was in the hospital once for treatment, and then for an operation on a duodenal ulcer.

All this happened between October of last year and February of this year. And now the doctor tells me that he suspects that our 11-year-old, Bret, is developing stomach problems, possibly even an ulcer.

With all the misery he's been through and seen in our family, I can understand why this is so. I'm not here, however, to tell you my tale of woe. I think we're confused in this country.

Most of my friends are insurance poor. They load up on health insurance because they're terrified of having to face a \$2,000 or \$3,000 hospital bill.

This is repeated over and over among our friends. I think the trouble is that we somehow have the notion that the insurance companies are going to be able to solve our health problems. It simply won't work.

I've watched health costs rise and rise and rise again over the last 12 years. And while the benefits from the insurance companies rise, it doesn't pay the whole bill.

When you have to face up to \$4,000 in unpaid health bills in less than 4 years, as our family did, and when you eat your heart out trying to pay this, and when the sick just keep getting sicker, then we need a new system.

This country has to change its way of thinking about health. Good health is not a privilege, it is a right. Every American, rich or poor, has a right to this good health. I say to you that we need to pass a law that makes good health care a right and a reality for all of us.

Let's turn off the misery that so many of us have been plagued with all our lives. I am 30 years old, and I think I've seen enough

misery for a whole lifetime. I hope you will make it possible for good health care to be a right, not in the distant future, but right away, in the rest of my lifetime.

Thank you.

(Mrs. Hentges' prepared text follows. Testimony resumes on p. 1299.)

TESTIMONY

My name is Judith Hentges. I live at 2639 Dove Street in Dubuque, Iowa. I am employed at the National Tea Company, and have worked there for eight years under a union contract negotiated by Retail Clerks Union Local 396 in Dubuque. I mention the union because it has had a very important impact on my life. If it had not been for my union's health and welfare program, my family would have faced certain economic disaster.

My late husband came down with cancer 12 years ago, just after the birth of our first child. I don't really want to live through all the horrible details again. Just let me say that my husband had 25 percent of his body amputated before he passed away last August, after more than 11 years of total disability. But coupled with his problem is the fact that my first baby developed hearing difficulty which has resulted in six major surgeries and constant attention from the doctors. He has also been down with such things as measles, meningitis, scarlet fever and an almost incredible number of other ailments.

The records of the union-negotiated health and welfare program show some interesting figures for me and my family. Since August of 1968, the program has paid us a total of \$13,202.26 in claims. These records show that there was a total of \$2,526 which we filed for but which was disallowed under the terms of the program. And it is a good program by all the standards I know. It pays far, far more than what many of our friends receive. And I shudder to think of where I would have been if I had been working in a non-union store where health and welfare programs are practically non-existent.

So we had to pay out \$2,526 from our own pockets. And it just wasn't there. I remember my husband Alan being upset because we couldn't seem to make out on his total disability payments from Social Security, plus what I was making. The fact is that we sat down and figured it out. At that point I added up all our bills for the year—gas, light, rent, all the rest—everything except food—and we had spent \$6700. But our total income was only \$7200 for the year. That's because I had to take time off from work to be with Alan while he was hospitalized for long periods at Iowa State Hospital, 90 miles from our home. There were other expenses you couldn't begin to count—gas for the car, food for me when I was at the hospital, dental and optical bills, special costs for all kinds of emergencies. Imagine, we were trying to take care of my ill husband, four children, my sister who lives with us so she can baby-sit the children while I work. Seven people on \$7200. We just could not make out . . . and it was even worse when we had to go on welfare when Alan first became ill.

I wish I could communicate to you gentlemen the terrible misery that affects so many working people like myself. There is real pain when you have to ask your parents to mortgage their home to bail you out and put food on the table. There is a terrible sense of hopelessness and monotony when you have to go down to the credit union for another loan, and then another, and then a loan to lump all the loans together and stretch it out so the payments won't hurt so much.

My husband was ill but that made him no less a man. He had to sit there and not show the hurt when the bowling league took up a collection on our behalf . . . or when the Gift Shop Circle at the hospital paid a hospital bill for us. There were the relatives and the friends who came by with money . . . loaned it or outright gave it. There was so much physical and emotional misery in our family that my husband himself suffered from a gastric ulcer before he died. The strain told on me, too, because I was in the hospital once for treatment and then an operation on a duodenal ulcer. All this happened between October of last year and February of this year.

And now the doctor tells me that he suspects that our eleven-year-old, Brett, is developing stomach problems—maybe even an ulcer. With all the misery he had been through and seen in our family, I can understand why this is so.

I'm not here, however, to tell you my tale of woe. I think we're confused in this country. Most of my friends are insurance poor. They load up on health

insurance because they are terrified of having to face a \$2000 or \$3000 hospital bill. This is repeated over and over among our friends.

I think the trouble is that we somehow have the notion that the insurance companies are going to be able to solve our health problems. It simply won't work. I have watched health costs rise and rise and rise over the last 12 years. And while the benefits from the insurance companies rise, it doesn't pay the whole bill. When you have to face up to \$4000 in unpaid health bills in less than four years, as our family did, and when you eat your heart out trying to pay it, and when the sick just get sicker, then we need a new system.

This country has to change its way of thinking about health. Good health is not a privilege. It is a right. Every American—rich or poor has a right to good health. I say to you that we need to pass a law that makes good health care a right and a reality for all of us. Let's turn off the misery that so many of us are plagued with all our lives. I am 30 years old and I think I have seen enough misery for a whole lifetime. I hope you will make it possible for health care to be a right . . . not in the distant future . . . but right away . . . in the rest of my lifetime.

Senator HART. Mrs. Hentges this is not to suggest anyone has taken aim at us, so I'm not saying this defensively. I'm simply making the warning that when we—as we must—become involved in discussions of loss ratios, contract languages, and extent of coverage, return on invested capital, there's the danger that we forget what it should be all about.

This massive industry is the basic reliance that we have to insure that families aren't destroyed as the result of illness or accident.

And it takes just a few minutes, really, to hear from you, that which serves to remind anyone who has forgotten in the maze of the complexity of the business, what we are really concerned about and what we're trying to do.

And your reminder is very sharp. It helps bring it all back to why we're here. We may have to get from Mr. Davis the answer to this, but what was the experience in obtaining from the National Tea Co., the insurance coverage that you described? How long have the retail clerks been able to offer that kind of protection to their workers?

Mr. DAVIS. Well, we've been early in on the whole health and welfare field, and as she suggests, she's been covered for 8 years, since she's worked for National Tea.

But the problem is that we deal basically with insurance companies, and we find that this is a dismaying experience. Even though we negotiate what are considered, you know, in the labor movement, to be pretty fair contracts, in the most cases, it's only covering two-thirds of the bill, and people are paying the balance of it out of their pocket.

Now, there are notable exceptions and meaningful exceptions. I would suggest, for example, Co-op of Puget Sound, which is an excellent program because it comprehends prepaid, direct service group practice program. It pays the whole bill. And this isn't negotiated by the employer, perhaps, almost the same amount of money. The same thing is happening with Kaiser-Permanente.

Those of our people who live in the area so they can be served by Kaiser-Permanente are getting comprehensive care.

And while there may be some reservations, let's say about the methods that Kaiser uses, there's no question about the quality of care. There's no question about the quality of care here in this city under GHA, HIP in New York, any number of group practice programs across the country.

The difficulty is that these are not acceptable to our people. There is no way for her to be covered by a comprehensive prepaid group medical practice program in Iowa. It doesn't exist.

In fact, there are State laws that prohibit this in many places. And this has brought the retail clerks around to the position that we've got to have a better system and a different system of health care.

We consider our present system to be a nonsystem, really. We need a system that will take care of the kinds of needs that she described, because we could produce horror stories by the hour. This isn't difficult. They're there to be found, as you know, Senator.

Senator HART. Mr. Sharp.

Mr. SHARP. Senator, I'd just like to ask Mr. Davis one question. You were here, I take it, when Mr. Skutt was testifying?

Mr. DAVIS. Yes, sir.

Mr. SHARP. We got into a discussion of coinsurance—deductibles. In any of your programs negotiated having coinsurance, do they pay full dollar other than the prepaid plan? I'm talking of indemnification.

Mr. DAVIS. There are deductibles along the way.

Mr. SHARP. Is there coinsurance?

Mr. DAVIS. Describe coinsurance.

Mr. SHARP. Describe it?

Mr. DAVIS. Yes.

Mr. SHARP. Let's say the patient or the employee picks up the first 10 or 20 percent—

Mr. DAVIS. Yes.

Mr. SHARP (continuing). And thereafter, the company pays. Now, do you feel—

Mr. DAVIS. Coinsurance is not all that common.

Mr. SHARP. Pardon?

Mr. DAVIS. Coinsurance is not all that common, deductibles are.

Mr. SHARP. Deductibles are?

Mr. DAVIS. Yes.

Mr. SHARP. This is with group plans I'm talking about.

Mr. DAVIS. Yes.

Mr. SHARP. Well, we have examined many plans here, smaller group plans that were submitted by the companies.

We have found 70 and 80 percent coinsurance clauses in the—

Mr. DAVIS. We have some.

Mr. SHARP. With small—

Mr. DAVIS. Yes. Correct.

Mr. SHARP. Do you feel that this is keeping people away from necessary care? When people have to pick up the first 20 percent, they kind of shy away from wanting to go to the doctor, or go for early treatment or diagnosis?

Mr. DAVIS. Well, it's been my experience that money is an obvious barrier to health care. You don't have to think about it too hard.

For example, I recall an experience that Kaiser went through some years ago. They had a nominal \$1 registration fee as you came in for an office visit at the doctor's office.

And in order to expand the base on which they could operate and to include more people whose total negotiated premium didn't amount

to what they had for this particular plan, they tried a different system, and they raised the fee to \$2.

Now, there's a study available on his. And they found a market decrease in people going in for attention simply because the fee had been raised from \$1 to \$2.

But when you're talking about 20 percent, you're talking about, you know, very large amounts of money. This is obviously a barrier to care. People just don't go because they feel they can't afford it.

Mr. SHARP. Thank you. We appreciate it.

Mr. HART. Mrs. Hentges, could you estimate the number of days or weeks that your husband was actually hospitalized as a result of the cancer?

Mrs. HENTGES. He was hospitalized around 3 months all together, a little over 3 months. This was in 1961. And then about 2 months following that, and like a week at a time in between there.

And then, over the last period, he had six major surgeries before he had his leg amputated, and he was in approximately another 4 or 5 months and then 5 weeks before he died, he was in the hospital at the time.

Mr. HART. Did you have any?

Mr. CHUMBRIS. No questions.

Mr. HART. Do you have any questions?

Mr. KERN. I have no questions.

Mr. HART. Mr. Sharp?

Mr. SHARP. No.

Mr. HART. Thank you very much again. In terms of the pages of this record, your appearance will be very brief, but will give very real meaning to this hearing.

Mrs. HENTGES. Thank you, very much.

Mr. DAVIS. Thank you, very much.

Mr. HART. We will recess, to resume at 2 p.m.

(Whereupon, a luncheon recess was taken.)

(Documents follow. Testimony resumes on p. 1299).

THE HEALTH CARE CRISIS: A STUDY IN HUMAN TRAGEDY

Supplement to the October 26, 1971, testimony of AFL-CIO President George Meany. Prepared by the AFL-CIO Department of Community Services

SECTION I

Case No. 1

Mr. and Mrs. Tim Olson of Sacramento, California, are too well off for Medical, and too poor to pay their medical bills. They face bankruptcy, have applied for welfare, and are unable to pay for the medical care Mrs. Olson needs.

Mrs. Olson has been sick for three years, going from doctor to doctor to learn what was wrong. Finally, after one surgery, five kidney infections, and a growing numbness in her torso, the doctors diagnosed multiple sclerosis. Medical bills will multiply as the disease progresses.

The Olsons incurred \$10,824.75 in medical expenses from 1968 to 1970. Of that total, \$5,509.86 was paid by Blue Cross for hospitalization, and EME paid \$573.13. The Olsons have been trying to pay the balance of \$4,598.10.

Case No. 2

An eight-year-old boy was seriously injured in an automobile accident which killed his mother. The boy, paralyzed with a spinal injury, was not expected to live. Because of his injury, he required a therapist and an inhalation machine which has to be operated by a special technician.

The boy is still alive almost a year later. His hospital bill for the first six months was \$45,000, of which the insurance paid \$17,000. He was then trans-

ferred to a children's hospital, where his bill is \$25,000 to date. His medical bills average \$5,000 a month.

His father earns \$24,000 a year, and has paid \$3,000 of the bills. Because of these facts, the hospitals claim the family is not medically indigent, and must pay the remaining \$50,000 in bills.

Case No. 3

Samuel Terry, a steelworker from Hueytown, Alabama, has been ill and unable to work since March, 1970. After four months out of work he began receiving disability payments from the company. They then counseled him to apply for his Social Security. He was turned down because they felt his disability was not severe enough to be out of work.

Sam later reported back to his doctor for advice about his Social Security and disability. His doctor re-examined him and reported to Social Security that his arthritis, low blood pressure and diabetic condition prohibited him from holding any type of job. He then reapplied for Social Security and was again turned down.

During another visit to his doctor's office, he suffered a severe gall bladder attack and was rushed to the emergency room of the hospital. Three days later, his gall bladder was removed. His ten days in the hospital cost him \$1,767, of which his insurance paid \$460. His \$300 savings also went toward paying the medical bill.

He sees no way that he will be able to pay the remaining \$1,000 of the bill. He is 57 years old, unable to work, physically disabled, and in pain most of the time.

Case No. 4

A 47-year-old woman from Cadillac, Michigan, is suffering from intersictel fibrous, a lung and respiratory disease.

Her hospital expenses are fully covered by her husband's insurance. However, the insurance does not cover the other medical expenses, and the couple's bills are mounting rapidly.

The woman requires 6 to 9 tanks of oxygen a week at \$10 a tank, and medicine runs \$10 to \$12 a week. Back bills amount to approximately \$900. Her husband nets \$94.70 a week. They do not qualify for Medicaid I; and Medicaid II, which they receive, only pays for hospital care.

Case No 5

Ruth Endinger of Akron, Ohio, has been ill since September of 1965, when she was forced to quit work at age 54 with a heart attack condition and excess fluid which was affecting her lungs and making her legs swell.

Since then she has been hospitalized four times, for a total of 93 days. The bills have totalled \$6,288.60, of which \$1,722 was paid by insurance, leaving \$4,566.60 for the patient to pay.

Her total income is \$189.80 per month. She is a widow and has two children who are unable to help her. She visits the clinic one to three times a month. She has been assisted by United Fund in paying for her medical care.

Case No. 6

Ethel Thomas, a widow, suffers from a heart condition, epilepsy, dermatitis and ulcers. She has to care for her widowed mother, who is an invalid. Because of her illnesses, she must pay a woman \$45 a month to help care for her mother.

Her mother receives Aid for the Aged, \$302 a month.

Mrs. Thomas has hospital coverage that has paid all her hospital bills, but she cannot afford to pay a private doctor and buy her medication. Therefore, she has to go to the hospital clinic, at a cost of \$20 or \$30 a month.

She will require a great deal of medical care for the rest of her life.

Case No. 7

Albert Lambert of Terre Haute, Indiana, wrote about the hardships he and his wife face because of their limited income and high medical expenses. They have a Major Medical Insurance Policy with a \$100 deductible clause. Their monthly income is \$158.80, since Mrs. Lambert had to quit working after two heart attacks.

In 1968 their medical bills amounted to \$764; in 1971 they reached a total of \$1,798.

"With these bills and such small income it is impossible to pay the bills and still be able to eat." Mr. Lambert wrote.

Case No. 8

A child, the family's third, was born with a congenital heart disease, bilateral glaucoma and Sturge Weber disease. The cost of medical care for the first year was \$12,129 exclusive of transportation, lodging, etc., for the mother when frequent hospitalizations in another city were necessary.

The family was covered by a fairly good major medical policy from the baby's sixteenth day of life with a maximum of \$9,000. With this coverage and as much overtime as the father could get, the family managed. However, as the cost climbed and overtime fell off, the family began what up to now has been a fruitless search for financial aid. The child's cardiac and visual problems will require constant, expert, expensive care all of her life. Because of complications during catheterization preparatory to an attempt of cardiac surgery, the child's leg has to be amputated.

An artificial leg, (on rental) must be replaced every 45 days at a cost of \$97, about \$700 a year for this alone. Frequent periodic replacement will be necessary until she reaches full growth.

Case No. 9

A 22-month-old boy from Jacksonville, Florida suffered from an immature digestive system. He received medical care costing \$2,937.30. Insurance paid for \$1,168.50, leaving \$1,269.80 for his father, Clyde Walker, to pay. Mr. Walker already works two jobs.

Case No. 10

A private businessman from Nebraska suffered from Hodgkins' disease over a period of years. He had some medical coverage, but after it was exhausted, he still owed over \$5,000. As he had no earning ability at this time, the people of his community raised money to pay part of his bills, and negotiated with the doctors to forgive part of the bill.

Case No. 11

Mrs. Robert Miller of Jacksonville, Florida became ill in 1967. After intensive tests, her condition was diagnosed and she was admitted into Baptist Hospital for surgery. The bill for the tests and the 26-day stay in the hospital was \$6,263.90. The insurance company paid \$1,124.25, leaving a balance of \$5,139.65 to be paid by the Miller's.

Mr. Miller paid on the bills for the next two years, and reduced the balance to approximately \$2,000. During this time the family was subjected to constant harrassment by collection agencies and finally a law suit by one of the doctors.

Being close to nervous breakdown and unable to pay, Mr. Miller filed bankruptcy.

The Miller's current medical expenses are approximately \$1,000 a year, and they face the distinct possibility that Mrs. Miller will have to return to the hospital for further surgery.

Case No. 12

A young couple with three young children is heavily in debt as a result of medical and related expenses. The husband earns \$6,000 a year as a factory worker, and cannot afford a telephone for their St. Paul apartment.

The wife recently had open heart surgery, and needed help in the home during her long convalescence. They have some hospitalization, but nothing to help pay the extra expenses related to her illness. They are not eligible for any financial aid for their medical expenses.

Case No. 13

A steelworker's wife, dying of cancer, requires the services of an LPN. So far this service has cost the couple \$3,000, none of which is paid by their major medical insurance.

They have borrowed \$8,000 by taking out a second mortgage on their home, but their continuing expenses will rapidly exhaust this fund.

Case No. 14

Four-year-old Jeff Hall is deaf and retarded. His family's insurance is exhausted, and they owe \$6,000 for hospital and doctor bills.

Case No. 15

Jack McCabe of Sunbury, Ohio, is disabled. His savings and insurance are exhausted, but he still owes \$1,250 for hospital, doctor and the oxygen which keeps him alive.

Case No. 16

Jordan Luther of Columbus, Ohio, is disabled and a terminal cancer patient. His wife is caring for him at home. They owe a balance of \$600 and have an income of \$40 a week. Their savings and insurance are exhausted.

Case No. 17

Paul Ruzicaska, Sr., is disabled and on Social Security disability. His savings and insurance are exhausted, and he was forced to sell his home to pay doctor and medicine bills.

Case No. 18

A 23-year-old former Lockheed worker at Marietta, Georgia, wrote that his 56-year-old mother suffered a stroke in 1966. She also had to have her left leg amputated below the knee because of diabetes. Subsequently, her right leg was amputated. At the same time she was losing the sight in her right eye and the hearing in her left ear.

She had a little private insurance and was covered by a small group plan at her husband's (the young man's stepfather) place of employment. Despite his mother's condition, his stepfather's low pay and doctor's statements, he was drafted into the Army. Meanwhile, her bills piled up higher than her limited insurance could pay.

The youth finally received a hardship discharge from the Army and went to work at Lockheed to pay off the bills. Last Summer he was laid off and shortly afterwards his mother had to be hospitalized for a severe kidney infection. His stepfather died late last August and his mother five days later. He is still struggling to pay off the bills.

Case No. 19

The wife of a union member with cancer had two final periods of hospitalization before death totalling 72 days at a cost of \$11,104.30 or an average of \$154 per day. Because of earlier admissions only 14 days were covered by insurance, leaving approximately a \$9,000 balance.

The member's income is \$170 a week. He has four minor children to support. He was not eligible for Medicaid because of his earnings.

One of the hospitals turned the account over to a collection agency. The agency suggested the following arrangement: on a bill of \$6,127.90, the finance charge is \$357.80, bringing the total indebtedness up to \$6,485.70 to be paid off in ten monthly installments of \$648.57. His approximate monthly earnings are \$730.

Case No. 20

The wife of a Textile Worker was hospitalized for two weeks, due to a miscarriage with complications. The hospital bill was \$1,994, of which the insurance paid \$1,299. The worker owed the balance of \$695. He was eligible for Medicaid, and received payment for one week. The insurance company took so long to make their payment that the time limitation for public assistance expired, and Medicaid would not pay the \$425 remaining.

Case No. 21

John Wilkinson, Sr., of Groton, Connecticut, recently received notice from Connecticut Blue Cross that his premiums were being increased. In the notice, they said: "We fully realize that some members might find the new rates a financial hardship. For this reason, Blue Cross offers you at this time only, the opportunity to select lesser coverage." Mrs. Wilkinson marked on the letter, "Isn't this preposterous?", and sent it back to Blue Cross.

Case No. 22

Mrs. Virginia Staley of Terre Haute, Indiana, enrolled in a group insurance plan in 1961, at a cost of \$7.50 a month. In 1969, she retired and continued the coverage with a great reduction in benefits, at a cost of \$13.55 a month, the rate for individual membership. She says, "In July of 1970, this premium was raised to \$15.29. I felt at that time that I could not hardly afford it. This year my premium has raised to \$18.22. I know that on the small pension that I receive that I cannot afford it for the coming year.

Case No. 23

The 15-year-old daughter of a union member had to be taken to the emergency room of a municipal hospital. She was admitted to the psychiatric service. The father was asked for and gave all data on insurance coverage.

After a few days the parents were told that their daughter needed the kind of care available at a voluntary psychiatric hospital and that the hospital would assume responsibility for transfer. The process took almost 4 months.

She was in the voluntary hospital for approximately 3 months. The total costs for the voluntary hospital stay was \$11,660 or an average of \$128 per day. The major medical policy covered the first \$9,000—its maximum. The balance was paid by the father, who a year later is still paying for out-patient care.

Six months after the girl's transfer from the municipal hospital her father received a bill for her stay in the amount of \$10,772.30. Since she had been in a municipal hospital, no Blue Cross insurance was applicable and the major medical policy with a top limit of \$9,000 had been exhausted by the voluntary hospital stay. Total cost of seven months hospitalization was \$22,432.

After months of effort the Central Labor Rehabilitation Council of New York was able to have the \$10,772.30 dropped but only with the help of the State Attorney General's office and on the technicality that the hospital, in demanding complete data about insurance coverage, had created the impression that the hospitalization would be covered. Also no financial inquiry or investigation had been made at any time to alert the family to the indebtedness and no bill had been presented until seven months after the transfer.

Case No. 24

A union member, unemployed, and collecting \$70 a week unemployment insurance went for emergency treatment to a local hospital. Several X-rays were taken and he was sent home with instructions to return the next day. He did so and was admitted to the hospital where he remained three days. Emergency room service cost \$185; the three-day stay cost \$900. Blue Cross would not pay the bill as the admission was considered to be "for diagnosis only."

Case No. 25

A union member's child was born with multiple defects which necessitated transfer to another hospital on the day following her birth. She was in the second hospital for 17 hours before death. The cost: for hospitalization \$660; physicians' fees \$1,275; making a total of \$1,935 for the 17-hour stay. None of this cost was covered by insurance because of the limitation on the first 15 days of life. Some reductions were made after weeks of negotiation by the public health nurse, but here efforts to accomplish more were thwarted by the member's fear of "causing trouble."

Case No. 26

When Mrs. Rudy King developed cancer in March 1965, she was insured under a group plan with Traveler's Insurance Company. (The group plan covered employees at the laundromat owned by Mr. and Mrs. King.) Travelers paid a portion of the first medical bills, and immediately refused her coverage under any insurance plan leaving a large doctor and hospital bill. The entire group plan was dissolved.

Mr. King approached several insurance companies, but was refused coverage on the basis of his wife's medical history.

Mrs. King has had a recurrence of cancer, has had radium treatments, and is under constant care for problems resulting from the treatment.

Mr. King has now taken a job as a janitor.

Case No. 27

An individual belonging to a group insurance plan with Mutual of Omaha Insurance Company had outpatient x-rays and then entered the hospital to have his gall bladder removed. While in the hospital he received a letter from the insurance company stating that they had received his claim for the x-rays, but that he no longer had insurance with them as they had not received his previous quarterly payment.

The man says he paid the premium, but had not received a cancelled check. The insurance company did not send a second notice or a notice of cancellation until he put in a claim.

The State Insurance Commission did a follow-up on the case and reported that in a group insurance plan the insurance company is not required to send these notices.

The man now has to pay a \$1,087 hospital bill, and \$84 anesthetist bill, and a \$420 doctor bill. Furthermore, he cannot get individual health insurance coverage as he has a slight heart murmur.

He writes: "I literally cannot afford to get sick in any way, shape or form."

Case No. 28

Mr. N of Hastings-on-Hudson, New York, had to apply for financial aid to pay his son's medical bills during 1970. Blue Cross had paid \$3,507.95; Mr. N still owed \$1,605.39, and the hospital sent him notice that unless the balance due them, \$135, was paid within 10 days they were turning the bill over to a collection agency. Mr. N earned about \$7,000 during 1970.

Case No. 29

A 53-year-old woman had one cataract removed, and soon after faced an operation on her other eye. Her insurance company cancelled her policy before paying for the first operation—they had discovered she had diabetes. She applied for financial help, but was turned down.

Case No. 30

Christopher Cramer is 18 months old and a mongoloid. He is also subject to frequent respiratory diseases, and required a tracheotomy.

His medical bills are:

Doctors—Children's hospital clinic.....	\$40
Dr. Stone.....	414
Dr. Awadalla.....	215
Dr. Hansel.....	150
	<hr/>
	819
Hospitals (Children's)	
5/22/70—six days.....	\$703. 45
6/1/70—43 days.....	9, 114, 30
8/17—four days.....	530. 90
11/21—five days.....	868. 80
	<hr/>
	11, 217. 45

Because Christopher is a mongoloid, the family hospitalization—Continental Casualty—refuses him hospital coverage.

Mr. Cramer is employed as a fireman, and has a net income of \$525.22 per month. Living expenses, including medical expenses total \$665.63 per month. The family is in desperate circumstances trying to pay these large bills, so private agencies such as Central Hospital Bureau gives partial assistance.

Case No. 31

A Teamster forced to retire by a severe heart condition cannot get health insurance. His income—a small pension and his wife's pay—is too high for Medicaid. He is not old enough to qualify for Medicare. Last year his medical and hospital bills were \$3,000.

Case No. 32

A 54-year-old Delavan, Wisconsin, woman had to quite work because of arteriosclerosis. Her group insurance won't accept her. She is not totally disabled so cannot receive Social Security disability benefits. She is too young for Medicare.

"What can a person in my predicament do except to urge Congress to pass a bill for universal health insurance?" she asks.

Case No. 33

A 21-year-old man faces bankruptcy because of medical expenses—incurred when his wife had a baby. He was discharged from the Navy a short while before the baby was born, and thought that his service insurance would cover the birth. A new law made this impossible. The couple has a large hospital bill and two good sized doctor bills.

The husband is underemployed; making just enough to be over the income standards set up by public welfare agencies.

He is now faced with expensive surgery for the removal of a growth from his ear, and will not be covered by insurance as he has not had his policy long enough.

CASES FROM THE HOTEL AND MOTEL TRADES COUNCIL OF NEW YORK

The Hotel and Motel Trades Council of New York has negotiated complete doctor care and Blue Cross coverage for union members and their dependents.

In 1970, the cost of maintaining Blue Cross was a little over \$3 million. The cost of their Family Medical Center was \$3,600,000. The total cost, almost \$7 million, is between 4½ and 5 per cent of all payrolls in the hotel industry.

"Even though thousands benefit greatly from this program," a representative of the Council has stated, "we find each year that we are operating at a deficit and must re-negotiate for additional employer contributions to keep going. With other unions, we are torn between asking more money for the health fund or for urgently-needed improvements to meet the rising cost of living."

The following cases come from their records:

a. A telephone operator was hospitalized 21 days for a nervous breakdown. Blue Cross paid for only two days. The balance of the bill—\$2,342.90—was paid by her husband, an elevator operator.

b. The wife of a maintenance man in the same union was hospitalized for Parkinson's disease in October 1968 and again for surgery in December. She was discharged Jan. 16, 1969. Since most of her Blue Cross was exhausted in October, it covered only \$1,234.94 out of a total bill of \$2,469.80. This left a balance of \$1,234.86 to be paid by her husband, whose take home pay is \$103 a week.

c. Luciano Valez will spend the next four years paying the balance of a hospital bill—after Blue Cross and Medicaid had paid their benefits.

His wife was hospitalized in the spring of 1970. Upon her discharge, they were confronted with a bill for \$986.12. Blue Cross had paid \$4,599.20. Since he was over-income for Medicaid, he could only be considered under the "catastrophic illness program"—whatever remains after he pays 25 per cent of his annual income. Medicaid, therefore, covered \$310.63 of his bill.

Mr. Valez is a 50-year-old worker; his take-home pay is \$84.33 a week. He will pay \$20 a month to Mt. Sinai Hospital for more than four years—provided that he works all that time and no one else gets sick.

d. Sol Edelman is a 63-year-old elevator operator, who required hospitalization for surgery on four toes. He exhausted his Blue Cross payments and applied for Medicaid. He was rejected by Medicaid not because of his wages, but because of his \$46 a week disability payments. Mr. Edelman owes the hospital \$221, which he will have to pay out of his \$80-a-week take-home pay.

CASES FROM IBEW LOCAL 640, PHOENIX, ARIZONA

Glynn Ross, business manager of IBEW Local 640, Phoenix, Arizona, has handled many cases in which the insurance company claimed excessive costs for medical procedures and refused to cover portions of the bills. Mr. Ross appealed the decisions on the basis that the patient had no control over the charges and that it was clearly unfair to penalize him. In nearly all these cases, he was successful in having the charges or the insurance benefits adjusted. But a great deal of paperwork was necessary—for the doctors, the medical society's insurance review committee, the insurance company and Mr. Ross. These are brief descriptions of some of these cases from the file Mr. Ross sent us:

a. William S. Kantor, Sr., of Glendale, Arizona, was billed \$1,373 for 14 days in St. Joseph's Hospital. His insurance company refused to pay \$86.50 of the charge for his semi-private room as it "exceeded the maximum amount allowable."

b. Joe Sandoval was charged \$50 because his insurance company claimed his surgeon's \$250 billing exceeded the maximum allowable by that amount.

c. Paul Bellanger received a surgeon's bill for \$1,170 for his son's foot surgery. The insurance company paid only \$750 for the procedure performed.

d. Betty Berry was charged \$75 for a hospital consultation, \$15.50 over the "usual and customary" fee.

e. Gary Downer's insurance company declined to pay \$60 on his hospital bill because hospital visits after surgery—regardless of need—are not covered.

f. Stephan Wallis was denied coverage on 50 per cent of his \$200 surgeon's bill because it "exceeds policy limitation for this procedure."

Insurance companies claim that refusing to pay charges "above the maximum amount allowable" constitute "cost control." The insurance companies costs may be decreased—at the consumer's expense—and yet the consumer obviously has

no control over the charges. Regardless of whether the doctor or the insurance company is at fault, the consumer pays. The only alternative is a complaint which leads to massive amounts of paperwork for all concerned.

SECTION II

Case No. 1

A 62-year-old man developed heart troubles and had to retire. He drew \$81 a month Social Security and could not afford medical insurance.

When he had to enter the hospital, \$400 was the required deposit. His daughter and her husband paid it out from the \$700 they had saved over a 14-year period. His son paid the rest of the \$2,000 hospital bill.

Now he is diagnosed as having lung cancer. His daughter's husband, Larry Kelley of Austin, Texas writes: "We have been to Social Security and they say they can do nothing. We went to Welfare. They said that Medicaid does not cover him. We pay taxes and we stand for Medicaid and then it doesn't cover nothing . . . The children he has have spent all their money. The old man has spent all his money. What are we going to do now? We can't just let him die."

"It seems to me, when a man has worked for fifty years and paid taxes, he ought to be able to rest and take life easy without having to worry about having enough money to pay some hospital or doctor."

Case No. 2

A disabled Vietnam veteran of Spanish-American origin in Albuquerque, N.M., sent in a copy of an \$11,283 bill he owes a hospital for care of his very ill wife. He also owes nearly \$5,000 to one doctor and lesser amounts to five others. He wrote:

"My wife just got out of the hospital. I have no way of any kind to pay the hospital bill. Everyone tells me the bill is too much. I had to take my wife out of the hospital because the bill was too much. She is very ill. Right now we are staying with my wife's mother. I need help real bad."

Case No. 3

Clarence and Doretta Kirksey have medical expenses totaling \$2,683 and a monthly income of \$433.73. Their regular monthly expenses are \$471. Mr. Kirksey does seasonal work.

They have seven children, two of which are chronic cases. James, age 7, has a kidney ailment, and Theodore, age 5, has convulsions. Six members of the family go to an open clinic, as they cannot afford a private doctor. They also have had several hospital bills.

There is no money in this family's budget for medical care. Yet they cannot receive any assistance from welfare because their income is over the budget allowed for a family of nine.

Case No. 4

Mr. S had a leg operation and was out of work for two months. He then returned to work, but after two weeks developed hemorrhoids. He had doctor and hospital bills to pay, and current household bills. The welfare office told him that he would be eligible for financial aid only if he had to stop work, and received no income.

Case No. 5

Mr. P—very ill with emphysema—needed oxygen but couldn't afford it. The nursing home he was staying in demanded money before they would give him any more oxygen. His wife appealed to the AFL-CIO Community Services office for help.

She and her husband had a monthly income of \$330 from Social Security. Medicaid was paying most of his expenses at the nursing home, but \$37 a month was deducted from the Social Security payment for the nursing home.

Mrs. P was referred to the city welfare office and was told that she "should speak with her husband's physician to see if his medical needs could be re-evaluated for hospital care since they cannot supplement."

Case No. 6

Mrs. Warren S has been sick—with diabetes, high blood pressure, shoulder and eye problems. She is unable to work. Her husband earns \$1.75 an hour, and is not always able to work 40 hours a week. They have no insurance, and applied for financial aid to help with medical expenses.

Their average monthly income of \$135 is not adequate to cover their regular expenses—\$225 a month, including drugs and doctor bills. They also owe back medical bills of \$495.

They had applied for aid previously, and received the following advice:
Welfare: If you weren't working, we could help you.

Indian Agency: Quit work and go back to the reservation and we can give you some help.

Welfare has since issued them a card to cover their medical expenses and to pay three months of back bills.

Case No. 7

An elderly woman was transferred from a hospital to an extended care facility for rehabilitation following a moderate stroke. At the time of the transfer the fiscal intermediary's office for Medicare said the care would be covered under the program. Several months later she received a letter of denial of payment from the Medicare intermediary. The bill for care came to over \$3,000. The elderly woman committed suicide. The note she left directed her sister to use the life insurance money to pay the bill. Suicide was the only way she could see for the bill to be paid.

Case No. 8

Mary Toe was admitted to the hospital for surgery for a blood clot in her lower left leg. Two days later the right leg had to be operated on also for blood clots. Further examination showed that she had a faulty valve in her heart that was causing the trouble. Heart surgery corrected the problem, and left Mary with \$13,000 in medical bills.

Case No. 9

Mrs. Donald Nelson of Sioux City was admitted to the intensive care unit of a hospital with a rare disease known as "Gullian Barre Syndrome". The disease has affected every muscle in her body, leaving her weak and helpless.

Medical expenses total \$400 per day in the intensive care unit. After three weeks she was transferred to a regular hospital room for perhaps two months at a cost of \$50 a day.

Sioux City residents are trying to raise funds to help the Nelsons with medical expenses.

Case No. 10

A 58-year old widow from St. Paul is suffering from severe anxiety and depression, brought on by financial difficulties and health problems.

She gave up her job as a cleaning woman because of illness six months ago. She owes \$9,000 on her house and says she will commit suicide if forced to leave it. Veteran's Assistance pays her \$80 a month while she is ill, and she receives welfare payments. She is not eligible for welfare assistance for medicines or fees for a private physician, and faces high unpaid medical bills.

Case No. 11

John Absten, Jr., wrote about the financial problems created by his wife Susan's illness. Susan suffers from a bone disease, dysplasia, and was hospitalized four times for surgery over a year and a half. At the time he wrote, Susan was about to be sent to the Mayo clinic for treatment. A trust fund had been set up in Tacoma, Washington, her home, to raise the necessary money.

Mr. Absten writes: "A great deal of money (all that I have been able to earn), has been spent on related bills.

"Our creditors keep pressing us for payment, so we have a continual output to doctors, hospital, anesthetist, X-ray and lab technicians, and drugs.

"My work as a carpenter apprentice is seasonal, so any extra money must be saved to live on during the winter. However, we haven't had any extra money, so with our two children we are living in a small one bedroom rental."

"I'm afraid this isn't going to get much better in the near future, as more hospitalization for my wife is imminent."

Case No. 12

A man with no insurance had a coronary and was taken to the hospital and given emergency treatment. The doctor wanted to place him in intensive care but the patient did not want to enter the ICU because of the high cost. The doctor agreed, against his better judgment.

Case No. 13

William Pender had cancer for 2½ years. When he died in November, 1970, he left medical bills totaling \$8,418.10. The most recent bill was for 28 days at the City Hospital, \$6,228.15. There was no hospitalization insurance.

His wife now faces years in debt to pay all these bills.

Case No. 14

Aaron Carroll of Columbus had cancer of the brain. His hospital bill was \$831 and miscellaneous medical bills were \$170, a total of \$1,001, before he was transferred to a Veterans hospital. He had no savings and no insurance.

Case No. 15

The Alexander family has faced serious medical problems and high medical expenses since their first baby was born in 1960, with a very small income. Mr. Alexander passed away in 1969 from tuberculosis, leaving Mrs. Alexander with seven small children. The family received ADC until Social Security was approved. Their income from Social Security is now \$369.90 per month.

The children all receive medical care at the Children's Hospital Clinic. Janet, age 10, has a kidney infection. Marvin, age 9, has asthma. Donald, age 8, had warts on his hand that became infected. Darl, age 7, spent time in Children's Hospital, and in the intensive care unit for a tracheotomy. Carol, age 5, has stomach trouble, and Karen, age 2, had an eye condition. Valerie died of burns in early 1970. Mrs. Alexander had a hysterectomy, and was hospitalized for 9 days. She was also being checked for TB and cancer. The bill was \$773.85.

Due to low income, this family will always need free medical care. Yet their income from Social Security is too high for them to receive welfare.

Case No. 16

Carter Wyatt, age 19, works at a laundry. He takes home \$278 per month. Mrs. Wyatt, age 18, bore two children in 1970. Carter Jr. (2/1/70) and Matt (10/13/70).

They owe the following medical bills:

Doctors -----	\$ 355.00
Hospitals	
1/29/70-2/5/70—Mrs. Wyatt-----	522.85
2/2/70-2/12/70—Carter, Jr.-----	233.00
10/13/70-10/16/70—Mrs. Wyatt-----	230.00
10/13/70-11/12/70—Matt -----	2,872.00
	<hr/>
	\$4,222.85

Case No. 17

The Sellers family has a total monthly income of \$442—which includes daughter Leatrice's pay, Mr. Seller's sick pay from Carpenter's Union, and Mrs. Sellers' earnings from day work. The family's living expenses, including payments on bills is \$679 a month.

Mr. Seller's has a kidney condition, ulcers and is anemic. The last hospital admission was for gastro-intestinal bleeding.

Medical bills:

Doctors \$529.00 and \$686.86.

Hospital 3,276.45 (12/4/70-1/4/71)

Including other bills, this family owes \$5,991.31.

A 59-year-old man—confined to a wheelchair with peripheral neuropathy—has high medical expenses, low income from Social Security, and no medical coverage.

He should have a monthly medical check-up, has a bill of \$600 with a neurologist and a large bill with a surgeon. He had much difficulty obtaining a medical check-up, which he finally obtained by personal contact with the neurologist, who did not agree to continue treatment.

He can obtain Medicaid for hospitalization, but not for transportation (he has no car), doctor's visits, medication or appliances.

Case No. 19

Mrs. Russell Tooze of Fresno, California, entered the hospital March 6, 1970 for surgery. She caught a cold while in the hospital and was sent home to recover (her husband was billed for this period although it was the hospital's fault she couldn't undergo surgery). She was hospitalized again on March 18 and discharged April 8. She became ill immediately and re-entered the hospital on April 10. She was discharged April 13. The bill for these days was \$2,000.56, not including doctor's fees.

She was admitted to the hospital again on May 7, and died May 24 of cancer. The bill this time was \$3,737.92.

Case No. 20

A student with Hodgkin's disease requires medical care which is expected to cost about \$35,000. His family has exhausted its income on medical care for his mother to the point that they cannot afford health insurance. The doctors will not take the case until \$25,000 is assured. The community and fellow students at the University are putting on benefit drives to help raise the money.

Case No. 21

A couple from Detroit, Michigan face medical expenses they cannot possibly pay. The husband, age 59, suffers from arthritis and must visit a physician twice a week for gold salts injections. The wife had a mastectomy in 1962 and still requires some drugs. Medications alone cost \$900 a year—of which one-third is paid by the Michigan Cancer Foundation's Colony Club.

The couple is unemployed. Their monthly income of \$341.30 comes from a pension and Social Security disability payments.

Case No. 22

Rudolph Gottfried of Columbus, Ohio, is totally disabled and has been bed-ridden for nine years. His wife cares for him at home as a nursing home is too expensive. No insurance, no savings. Their total income is \$177 per month. They still owe the hospital \$350.

Case No. 23

The Clear family visits public health facilities because a private doctor will not take this family due to low income. Yet the Claars still face medical bills they can't afford to pay.

Mr. Claar has been disabled since 1962, received welfare benefits until 1969, and since then has received Social Security. Mrs. Claar has a fifth grade education and has never worked outside the home.

The family's monthly income from Social Security is \$306.80; their monthly expenses in the home \$364.26.

Mr. Claar suffers from emphysema and bronchial asthma. Mrs. Claar has high blood pressure, a thyroid condition and a kidney infection. She has had surgery three times since 1967. Terry, age 13, has a spinal condition and eye trouble. He wears corrective shoes and needs his glasses changed every year. He may have muscular dystrophy.

Their medical bills are:

Children's hospital (3/29/70-4/1/70)-----	\$408.00
Clinic visits-----	350.00
	<hr/>
	\$758.00

Case No. 24

A 28-year-old woman who had been receiving care from a private physician during pregnancy went into a private hospital in the last stages of labor and delivered. The husband had abandoned her and the three older children a month or so prior to delivery. The hospitalization insurance was no longer in effect and she had no funds. She was discharged from the hospital two days postpartum despite the fact that she had a difficult delivery. She went home with \$22 worth of prescriptions and with what appeared to be severe draining perineal infection. She had no money either to buy the medications or food for the new infant.

Case No. 25

A child had open heart surgery in December 1970. Hospital and doctor bills amounted to \$4,000. The family had no hospitalization, and no agency could assist with the bill because of the family's income. Therefore, the family will be paying the bill for many years.

Case No. 26

The 23-year-old son of a postal worker was injured and was not covered by the family hospitalization policy. Doctors say he will never leave the hospital. The father signed to pay the doctors and hospital. The bill is now over \$10,000 and still growing.

Case No. 27

Mrs. O has asthma and a bad back, and has had a cancer operation. She wants to work but has not been able to find a job. Her husband earns \$75 a week. Their medical expenses have been very heavy—and they are now three months behind in their rent and are running out of food. The city welfare told them that their income was too high to receive aid.

Case No. 28

Mrs. E's two children were seriously burned, one died soon and the other was not expected to live when the appeal for aid was made. Mrs. E had no insurance, and a friend was trying to help with expenses by putting out a contribution jar in her store.

Case No. 29

A woman with seven children and two grandchildren living at home appealed for financial aid so she could pay for medical care for her husband. He had been ill for five months. When he went to the medical center for care, he was turned away. The wife's take home pay was \$92 every two weeks.

Case No. 30

Mrs. P had an auto accident in 1967. Her medical bills were very high and she couldn't work. Her husband earned \$400 a month. They had one child sick with a brain tumor. Their credit rating was poor, they needed better housing, and they owed two loan companies plus the hospital and doctors; so they were forced to apply for welfare.

Case No. 31

Officer C.—a police officer for 12 years—needed financial aid to help pay his wife's expenses on a kidney machine, and her hospital bills. She has been hospitalized for 32 days. The kidney dialysis machine will cost them between \$3,000 and \$4,000, and maintenance runs at least \$150 a week. The Order of Police has been helping with the doctor bills, but cannot keep up with the huge expenses for the machine.

Case No. 32

Mabel Colvin of Addison, New York, entered the hospital on November 30, 1969 with a broken hip, and was discharged March 7. Three-and-a-half months after discharge, she received a letter from the hospital saying Medicare had paid her expenses from November 30 until February 5, but that the final month of her stay was ineligible for Medicare benefits. Therefore, she owed the hospital \$1,094.40.

Her daughter, Mrs. Doris Bliss, wrote to Medicare to find out why they wouldn't pay. They replied that "she did not require skilled nursing care on a continuing basis according to the Medicare regulations." Yet Mrs. Colvin's physician had refused to release her because she had developed a heart condition. The daughter appealed the decision, but Medicare stubbornly maintained its original position.

Mrs. Colvin passed away in early 1971, and the daughter now faces paying her hospital bill of \$1,094.40. Mrs. Bliss wrote to a local union, saying "perhaps with the help of a union like yours working on this, something can be done. It is hard for older people with little or no money to be stuck with a bill of several hundred or thousand dollars."

SECTION III

Case No. 1

Mrs. Marilyn Osborne—age 21—died two weeks after she was refused admission—although she was in active labor—to Prestonburg, Ky. General Hospital. Her baby was born at home 15 minutes after she returned from the hospital. She said the hospital would not accept her insurance or a personal check. "I think it was awful to call the city police and run us off," she wrote before her death.

Case No. 2

"When you don't have any money or insurance, they can give you lots of advice but you won't get any help." These are the words of a woman who should know—she is now a widow because no one would help her husband.

Her problems began in November when her husband, an alcoholic, became seriously ill. She called a hospital clinic and was told to bring him there. She didn't have a car or the money for an ambulance, and the fire department refused to take him to the hospital because the situation was not an emergency.

A friend helped her carry her husband to the friend's car. When they arrived at the hospital, they learned that there would be a long wait and a \$5 fee. They did not have \$5 and so they left.

A few weeks later she took him back to the hospital emergency room, although she had no money, because he was so sick. A doctor gave him a shot and sent him home. She wasn't able to pay that bill.

In January her husband became desperately ill. "His stomach was swollen so he looked like he was nine months pregnant. He was yellow and was so weak he couldn't get out of bed," she said.

She called a doctor. He came and looked at the patient, and said he had a "sick liver" and wouldn't live a month unless he was in the hospital. The doctor told the woman to call the welfare department.

The welfare department told her that her income of \$1.75 an hour disqualified her for aid. "I told them I didn't want nothing for myself I just needed help for my husband," she said.

The next day her husband appeared to be getting worse. She called a hospital again, and was told to make an appointment the following week at a clinic. She tried another hospital but was referred from one number to another. Finally she reached a woman who offered to help. This hospital worker attempted to reach a doctor who specialized in treatment of alcoholics, but he was out of town.

A few hours later her husband died.

"I didn't know where to turn," the widow said. "I was stopped and always referred back to welfare."

Case No. 3

United Auto Worker's Local 863 purchased a kidney machine for one of their members because there was none available in Cincinnati at the time. The machine was set up in the hospital where he was a patient. Supplies to use the machine amounted to approximately \$100 a month. The hospital refused to furnish these supplies until a standing bill of \$400 was paid. Another collection had to be taken from his fellow employees to pay the bill. The machine was donated to the hospital after the man's recovery.

Case No. 4

An Ontario, California, wife in a family of limited income, reports that for five years she has tried to find a doctor who will accept her as a regular patient. Medical Association officials in the area have told her they know of no doctors accepting new patients.

Very concerned, her children sent her back to her former doctor in New York. He found she had a sprained back, abdominal tumors and a cyst on her face. Armed with the New York doctor's written diagnosis and prescriptions, she tried unsuccessfully to get five different doctors near her California home to accept her. She couldn't even get her New York prescriptions filled on grounds the New York doctor was not licensed in California.

Case No. 5

Mrs. D. is an 18-year-old expecting her first baby. She has no private insurance. She has been seeing a private physician and planned to deliver at a private hospital. When she realized she would not have enough money to pay a private hospital bill, she attempted to discuss the possibility of delivery at the county hospital with her physician. He told her she would not be allowed to deliver there since she had already been seen by a private doctor. He became so angry with her that he left the room without continuing the discussion or even telling her when she should return to see him. She was advised by the public health nurse to telephone the hospital's social service office.

Case No. 6

Mrs. H.'s 2-week-old infant, was seen two times at a county hospital and told he had a "fungus infection". He became worse, sounded congested to the mother. She had an older child also who "sounds like she has bronchitis". She has called ten doctors. She was either told they didn't take patients on such short notice, or wouldn't take Medicaid recipients. She was given three physicians to call and instructed to call the public health nurse if she had no success.

Case No. 7

Mr. P. is in a work training program. He had only been in Polk County for six weeks when his wife developed acute abdominal pain. He was told by the County

Hospital personnel that she could not receive treatment there because they are not Polk County residents. He had a list of suggested physicians from the County Medical Society. He had called all of the physicians the Society suggested and none of them would see the patient. He was given the names of three doctors the public health nurse was certain would see her and instructed to call back. One of the physicians finally did agree to see her. (The husband wasted approximately four hours in his attempt to locate a physician.)

Case No. 8

A Des Moines widow in her early 60's was injured in an auto accident in Minnesota. She was hospitalized there for a month with both legs fractured in several places.

The legs were in casts when she returned to her Des Moines apartment by ambulance. The physician who cared for her in Minnesota was supposed to write a letter of referral to a Des Moines physician, but he left for Europe without sending the referral. For days she called physicians' offices but no one would make a home visit. She was told to come into the office.

In desperation she called the public health nurse who made a home visit. The nurse personally contacted the Medical Society. A physician finally did make a home visit, and prescribed needed medication and took the responsibility for getting medical records from Minnesota.

Case No. 9

A 58-year old man with a radical stomach and bowel resection due to cancer was discharged from University Hospital in Iowa City. A social worker referred the patient to the Public Health Nursing Association via telephone. The patient was on his way to Des Moines by ambulance at the time. The nurse arrived along with the ambulance and the patient. The ambulance attendants were unloading him onto a mattress on the floor. The apartment was in deplorable condition and his wife was in an alcoholic haze.

Somehow the medication for pain had been left behind in Iowa City.

The couple were not receiving public assistance. He had been unable to hold a regular job for over 9 months because of his health. No one had told them about applying for Social Security disability.

The County Hospital had no report from University Hospital as to the type of surgery or necessary medications. In any case, they would only prescribe medications for patients examined there. Numerous physicians were called, but no one could or would make a home visit. The Social Worker sought unsuccessfully for several hours to contact a staff physician in Iowa City.

The patient's pain became so severe by late afternoon that he had to be sent to the County Hospital by ambulance to receive medication for pain relief.

Case No. 10

The police called and asked for public health nurse assistance in getting a patient upstairs to her apartment. The nurse found 2 policemen and 2 ambulance attendants attempting to lift a 300-pound, 38-year-old woman up a narrow staircase. She was discharged from a local hospital 10 days following bilateral hernia repair. The abdominal incisions were both open and draining green purulent drainage. The woman was receiving ADC, and because Iowa Medicaid was a 10-day hospital inpatient limitation, she was sent home from the hospital. The woman had a severe staph infection. The public health nurse talked with the physician and he ordered that the wounds be irrigated daily by the nurse with Hydrogen Peroxide. After several days the nurse could see little improvement. She called the physician again. He reported that there had been no laboratory culture and sensitivity of the drainage done in the hospital. In order to prescribe antibiotics which would be appropriate this should be done. The nurse took drainage specimens and arranged for a laboratory to run the needed tests. On the basis of the laboratory reports, antibiotics were finally ordered 8 days after her hospital discharge. It took another month of daily irrigations to get the abdominal incisions healed.

Case No. 11

A woman from Oakmont, Pa., is desperately in need of a kidney machine, but is unable to purchase the machine, due to its cost. The hospital told the woman she must have 20 percent of the \$15,000 cost before the machine can be delivered. The family has major medical insurance, but does not have the cash to buy the machine.

Case No. 12

A member of the Glass Bottle Blower's Association is being treated for allergies, at a cost of \$33 per treatment. The state of Illinois would pay \$17 on each treatment, but the doctor insisted on cash payments.

The patient has been sick and out of work for a year. He receives a Social Security pension, has applied for a disability pension and needs the State aid.

Equally as tragic are the case of people who don't even try to obtain medical care. They don't know what help is available, and those agencies and medical facilities that might be able to help don't know they exist.

Improving the coordination of welfare agencies and developing neighborhood health centers might save some of these people. When the idea that health care is a right becomes a reality, the poor will know enough to seek help when they need it.

Case No. 13

Robert Ellis—a nine-year-old Louisiana Boy—died of starvation on Thanksgiving Day, 1969. He weighed 30 pounds. His five brothers and sisters were all undernourished and drastically underweight. Police took the dead boy and the five other children to General Hospital. The five will be sent to a home for dependent children when they leave the hospital.

The mother, Mrs. Ellis, receives a monthly welfare check for \$179. Her husband said he makes between \$4 and \$10 a day as an odd-job repairman. The parents said they have little money left for food after paying the bills.

Case No. 14

A 9-month-old girl's toe was gnawed off by a rat in a Louisville apartment in April, 1970. She also had deep rat bites on two other toes and suffered from an apparent malnutrition problem, in the form of anemia. The mother, Rose Ellis, said she had never had a job and had been turned down by welfare because the man who shared her apartment made too much money.

Case No. 15

In February, 1970, elderly Mattie Davis died of pneumonia. She weighed 80 pounds, was partially blind and deaf, and had been ill, without receiving care, for about three weeks.

"I couldn't believe that nobody was aware of her condition," a social worker remarked. "Everyday, all around us in this neighborhood, people are dying slow, quiet deaths."

SECTION IV

Case No. 1

Luis, a Puerto Rican Steelworker, was hurt in a mill accident resulting in the loss of three toes. He received workmen's compensation, and the company doctors performed the amputation and gave satisfactory treatment.

Five days after the amputation, Luis' family doctor, a fellow countryman, heard of Luis' misfortune and visited him at the hospital. Almost every day, for the next 34 days, the doctor had a friendly visit with Luis. A week after Luis was released from the hospital, he received a bill of \$340 from his good friend.

Case No. 2

Mrs. Charles Adams lost her husband in February of 1970. Medicare paid for all the hospital costs, yet in August she received a letter from a collection agency in another town stating that a doctor was about to sue her for a bill owed by her husband. She said he had not seen a doctor there or even visited the town. She says of the incident, "I have heard from others that they too have had the same things happen to them and I think that more people should be aware of this practice."

Case No. 3

William Adams of Terre Haute, Indiana, accidentally burned his hand. He went to the hospital for treatment, and his insurance paid the hospital. Later Mr. Adams received another bill from his doctor for \$18 for an office call to change the dressing. Mr. Adams says: "I'm sure the doctor knew that I had insurance when he sent me the bill. When I asked him about the bill he made the statement that I shouldn't worry about it since he was sure the insurance would pay for it, which they did."

Case No. 4

Edna Dean was sick with vomiting and entered St. John's Episcopal Hospital in Brooklyn as an emergency case. She spent 9 hours in the hospital and was charged \$319. The hospital refused to supply a detailed itemization of this bill and said a court subpoena would be necessary.

Case No. 5

A man in his early 40s, with three small children was admitted to a municipal hospital where he remained for 251 days at a cost of \$23,887.43, an average of \$95 per day. His insurance provided a flat daily rate which covered only $\frac{1}{4}$ of the cost.

The patient's and his family's distress was aggravated by their inability to collect disability benefits because of the hospital's failure to send the necessary reports. The reason given was that no diagnosis had been established. Through the efforts of a medical consultant, an intensive work-up was done which revealed a malignant tumor of the hip with metastasis.

The patient died within five weeks and the Central Labor Rehabilitation Council of New York negotiated for a cancellation of the bill. Their medical consultant's criticism of the quality of care was so severe that the hospital feared a possible suit for malpractice.

AFTERNOON SESSION

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA BEFORE THE SENATE SUBCOMMITTEE ON ANTITRUST AND MONOPOLY, PRESENTED BY LESLIE P. HEMRY

Senator HART. The committee will be in order. We are resuming this afternoon and we will receive the testimony of the president of the Health Insurance Association of America, Mr. Leslie P. Henry. Mr. Henry.

Mr. HEMRY. Thank you.

Senator HART. We will order printed in the record your prepared statement and anything that may be attached.

(The full statement follows. Testimony resumes on p. 1315.)

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

My name is Leslie P. Hemry. I am President of the Health Insurance Association of America. With me are John P. Hanna, Vice President and General Counsel, Louis A. Orsini, Director of the Health Insurance Council, and David Robbins, Director of Statistics and Controller. The Association has 321 member insurance companies which are responsible for 84 percent of the health insurance written by insurance companies in the United States during 1971.

This statement provides a summary of the performance and accomplishments of insurance companies in the following areas of health care and its financing: service and growth of coverage, scope and adequacy, administrative expenses, cost and quality control, and compliance with state regulation. The statement also indicates where we feel the record must be improved—and just how we propose that this be achieved.

It is acknowledged that our health insurance system needs to be strengthened and examined in terms of its relevancy to the health care needs of today. New concepts are emerging from the health insurance business and our activities and interests are broader than the financing mechanism alone. There are problem areas in our health care delivery system. These problems often interact with one another to create further distortions in the system.

We may not all agree on what is cause and what is effect in this area. We may not agree on the extent, solution or priority of any one problem. We cannot fail to agree, however, that our health care system needs attention and what is right about the system should be preserved and what is inadequate should be corrected.

THE GROWTH AND DISTRIBUTION OF PRIVATE HEALTH INSURANCE

A prime test of any business is product acceptance in the market place. The steady year-by-year growth in the numbers of people protected, and benefits paid out, by private health insurers is a clear indication that it is valued by the public and has worked to their advantage.

In 1940, some 12 million people in this country had hospital expense protection (only nine percent of the civilian population). By 1950, the proportion had grown to 51 percent and, by 1960, it had reached 77 percent. As of December 1970, some 170 million persons, over 90 percent of the civilian population below age 65, according to our estimates, were covered for some or all of their hospital expenses. Of the total with such coverage, over 107 million were protected by insurance companies.

The growth rate of surgical and non-surgical medical expense coverages has been of the same order of magnitude. From a mere five million persons covered in 1940, surgical expense protection had been provided over 162 million persons under age 65 by the end of 1970. (Of the total, about 100 million were covered by an insurance company policy.) For non-surgical medical expense coverage (protection for doctor visits and diagnostic x-ray and laboratory expenses), the growth over the 30-year period was from three million people to 137 million (some 76 million of whom were under insurance company policies). It is significant to note that the business continues to grow.

These coverages—essentially, hospital-oriented—were appropriate for their time, and health services still tend to revolve around the hospital as the center of medical technology. Rising demand for these services, coupled with increased wages, complexity of equipment and techniques, general inflation, and inefficiencies, have continued to push up the cost of hospital and hospital-related care. This, in turn, has further accelerated the demand for hospital expense protection (as the most costly of health care items), particularly by unions at time of collective bargaining. The demand for coverage of expenses incurred outside the hospital has not been as great.

Over twenty years ago, however, insurance companies recognized the need to cover the costs of medical care provided outside the hospital, and the need to provide protection against the large expenditures which result from catastrophic episodes of illness. In 1951, insurance companies developed major medical expense insurance. This coverage has grown from 108,000 people in that year to over 76 million under age 65 by the end of 1970. Blue Cross-Blue Shield, and other prepayment plans, also have come to provide major medical and comprehensive-type protection. When their enrollment is added to insurance company coverages, we find over 100 million Americans with catastrophic expense protection against costs incurred both in and out of the hospital, including the costs of treatment for mental illness and prescribed drugs.

Experimentation continues with other forms of coverage. In the early sixties, insurance companies began to offer dental expense coverage and, by 1970, had enrolled about seven million people for such care. Coverage for vision care and nursing home care are now being offered. Growth of these coverages up to this time has been limited by a lack of demand from the consumer.

Two further points with respect to insurance company enrollment should be underscored:

1. About 76 percent of the 107 million persons whom we insure are protected under group insurance policies. Employers pay approximately 80 percent of the total cost of such group plans for their employees. A recent study of the Association indicates that half of the employees have the full premium cost paid by their employers; an additional one-fourth have three-fourths of their premiums paid for; some 16 percent have half of the premium paid for; about 6 percent have a fourth of their premium cost paid. Less than one percent have to pay for the entire cost of the plan.

2. Seventy-six million, or 71 percent of the 107 million persons whom we insure, are protected by either a supplementary or comprehensive major medical expense policy. As has been indicated, such policies provide extensive benefits for costs incurred both in and out of the hospital.

THE SCOPE AND ADEQUACY OF PRIVATE HEALTH INSURANCE

If acceptance is a prime test of a product, then the growth patterns described above clearly indicate that private health insurance has passed the test—and passed it with honors. Of course, acceptance in terms of sheer numbers of

purchasers is only one aspect. The product purchased must also meet the public's needs. We have made every effort to do just this—with constant refinements to improve the adequacy of benefit plans.

One measure of the "adequacy" of private health insurance is employed by statisticians at the Department of Health, Education, and Welfare (HEW). These analysts choose to evaluate private health insurance by relating private health insurance benefits to the total consumer expenditures for personal health care in the country. This HEW approach, which in our opinion does not provide a valid basis for evaluating the effectiveness of private health insurance, reveals the following:

1. In fiscal year 1949-50 (the earliest period reported), private health insurance payments for hospital care represented 32 percent of consumer expenditures for such care. By 1970-71, this proportion had grown to 73 percent.

2. For payment of physicians' services, the rate of growth in "adequacy," again according to HEW, has been even greater. In 1949-50, 11 percent of consumer expenditures for physicians' services were covered by private health insurance. By 1970-71, the proportion had reached 48 percent.

3. The proportions of consumer expenditures for other health services covered by insurance benefits have been much lower: less than one percent in 1949-50 and almost six percent in 1970-71.

We believe that the foregoing analyses, while of some general interest, are not valid for the following reasons:

1. The denominator of the HEW equation cited above, namely, consumer expenditures for personal health care, includes the expenditures of uninsured people as well as insured. Obviously, insurance benefits cannot be paid to persons without insurance.

2. The denominator also includes the expenditures of all consumers, whether insured or not insured, for all items of "health care." Thus, in addition to expenditures for hospital, doctor, dental bills, and prescribed drugs, the denominator includes consumer expenses for non-prescribed drugs and medicines (aspirins, antacids, cough drops, and the like), appliances (ice packs, heating pads), household supplies (bandaids, kleenex, sanitary napkins), private room accommodations in hospital (which may or may not be medically dictated), rental of T.V. and radio in the hospital, cosmetic surgery, veterinarians' services, and a host of other expenditures not likely ever to be covered under any national health plan.

When health insurance benefits are related to people who are insured, and to the kinds of expenses they have chosen to cover, a truer picture emerges. Over half of all claimants under group policies written by insurance companies are reimbursed for at least 90 percent of the expenses they have covered, and three out of four collect at least 70 percent. Overall, according to our studies, insurance reimburses about 80 percent of the charges incurred. This proportion varies from 86 percent for the cost of hospital care to 77 percent of the costs for surgery to 61 percent of the costs for prescription drugs.

There are other indications of the adequacy of private health insurance as follows:

1. During the last 20 years, health insurance enrollment has more than doubled while the benefits which its insureds have received have multiplied 17 times. A part of this benefit growth is, of course, a reflection of the effect of inflation; but the increase from but \$900 million paid for medical expenses by all insurers twenty years ago to over \$15 billion in 1970 is most significant. Insurance companies provided \$7.3 billion of the 1970 total.

2. Some 70 percent of the people covered by insurance companies have major medical insurance which, as has been noted, pays for bills in and out of the hospital, including prescribed drugs, private duty nurses, and prosthetic appliances.

3. For those with major medical under group plans, more than nine out of ten have a maximum benefit of \$10,000 or more; seven out of ten have a maximum of \$20,000 or more. Almost one in four have benefits of \$50,000 or more. And benefit limits continue to expand. There are now plans which offer up to \$250,000 in benefits.

4. For those covered under group "basic" policies only (as compared with basic plus major medical policies), about a third have protection for 365 days of hospital care. More than four out of every ten have full coverage of the ward or semi-private hospital room accommodation.

THE COST OF ADMINISTERING PRIVATE HEALTH INSURANCE

It is to be noted that insurance companies, to remain competitive among themselves, as well as with other types of insurers which enjoy certain tax and hospital reimbursement advantages, must keep their costs as low as possible. At best, health insurance is a low-profit business. In recent years, our profits in the aggregate on *group* health business have been non-existent and have averaged less than two percent on *individual* health care business.

As to group marketing and administrative costs, a recent Association survey indicated that such costs averaged only eight percent of premiums, exclusive of the 2.1 percent paid in State premium taxes. This is an overall average made up of group plans with less than 25 lives and jumbo cases involving 500 or more employees. Large plans are administered for considerably less.

Comparisons of insurance company administrative costs are sometimes made with the cost of administering the Social Security program. Such comparisons fail to take the following factors into consideration:

1. The administration of the OASDI program (at two percent of premiums) is not nearly as complex as is a health insurance program. The OASDI program is a cash benefits plan in which 17.1 million persons are issued a monthly, predetermined check.

2. The SSA-supervised Medicare program has been running at four to five percent of premiums. This is a program, a group case if you will, with 19 million lives and more closely approximates a private health insurance group plan. No private carrier currently has a group plan with an enrollment of this magnitude. If one did, however, it is conceivable that its costs for such a group would be lower. Note, for example, that the Federal employees program (472,000 enrollees) is being administered privately at about 3 percent of premium, exclusive of taxes.

It has been noted that three-fourths of the persons covered by insurance companies are under group plans with their lower administrative costs. Operating costs for individual insurance are necessarily higher, averaging about 42 percent of premium, exclusive of taxes. The relationship of benefits paid to premiums received can be easily misunderstood and misinterpreted for both group and individual coverages. Comparisons of loss ratio figures from one policy to another are especially misleading unless they are based upon similar premiums, coverages, underwriting rules, company reserves and claims administration practices. Variations in any of all of these areas may alter the loss ratio picture. Caution in the use of a loss ratio, as the single measure of effectiveness of coverage, without the consideration of all relevant factors, has been recognized by insurance academicians.*

Why the marked difference between *group* and *individual* coverages? In the simplest terms, it is because the cost of doing business is higher for individual insurance than for group in the broad areas of sales, underwriting, administration, and conservation of existing policies.

To sell individual insurance, the insurance agent must contact each potential policyholder, and explain the coverage. This is a time-consuming and costly operation. To illustrate, it clearly requires more man-hours and effort—and hence higher agent compensation—to sell fifty individual policies than the sale of a single group plan covering fifty employees.

Underwriting also poses difficulties. A group insurance plan normally comprises a reasonable cross section of people in varying degrees of health. This balance is assumed in setting the premium rate, with no individual underwriting required.

With respect to individual insurance, each applicant must be individually considered. This is a necessary but costly procedure to protect against "anti-selection"—that is, the enrollment as standard risks of people who know or suspect that they are not in good health and will shortly incur medical expenses.

*For example, Dr. Ralph H. Blanchard, Professor of Insurance, Columbia University, said:

... A high loss ratio may mean adequate reserves, excessive reserves, poor risks, or lavish loss settlements; a low loss ratio may mean inadequate reserves, careful selection of risks, an inefficient claim department, or extraordinary good fortune. A high expense ratio may be the result of inefficient management, careful provision for the future, or unusually good service to policyholders; a low expense ratio, the result of efficient management, unwise retrenchments, or inferior service . . . Ratios, unless viewed in the light of the causes which have produced them, are never conclusive; they are least valuable when they are the result of limited experience.

To do otherwise would require spreading the added cost of "antiselection" among all policyholders. This would be an unfair penalty, and in the long run, could price individual insurance out of the market for many families.

Insurance company underwriting is based largely upon assumption of the "normal risk." These are people in reasonably good health who need protection because no one can predict the individual risk with certainty. This, indeed, is the very heart of the insurance concept and, of course, encompasses a very large segment of the population. It permits plans to be designed and benefits determined that are actuarially sound in covering as many people as possible. It also allows for economically priced plans for as many people as possible.

Individual insurance coverage of the physically impaired may be obtained in various ways. Payment of benefits for the specific condition may be excluded. This type of policy is useful because a person with an impairment is still susceptible to disability from other causes. Other approaches are to increase the premium to compensate for the greater degree of hazard or to impose a longer waiting period or shorter benefit period with respect to the condition.

However, the insurance business recognizes the barriers confronting many of these individuals, and the urgency of their social and economic need. Under the national health insurance plan supported by insurance companies—the National Healthcare Act (McIntyre Bill)—all persons with physical impairments would have available to them the same benefits as the rest of the population. These would be provided through state pool plans of private health insurers.

There are other important distinctions between group and individual insurance which affect operating costs.

Each group plan usually involves only one premium billing and collection regardless of the number of persons covered. If the plan is contributory, the employer is responsible for collecting the employee contributions through payroll deductions. Also, the employer usually explains the coverage to employees and keeps the necessary personal records of each worker and his dependents.

On the other hand, premiums for individual policies must be separately billed and collected by the insurance company. This is a significant expense, despite the efficiency of modern computers. Record keeping for each policyholder is handled by the company.

The cost of maintaining existing coverage in force is lower for group insurance than for individual. A group plan, once established, tends to be continued by the employer, subject to modification as needed. In contrast, individual coverage frequently is of short duration. It may be "stop gap" protection during a period of unemployment. As a result, insurers often have to amortize their acquisition expense on individual policies over a much shorter span of years.

Finally, the average benefit purchased, and hence the premium base to which the dollar operating cost is compared, is smaller under individual coverages at the present time.* This is largely due to two factors. One, consumers sometimes are reluctant to purchase more expensive, comprehensive protection. And, two, many individual policies are purchased solely to supplement group plan benefits.

In summary, comparing group and individual insurance expense ratios—that is, the ratio of costs to premiums—is simply not valid.

However, every effort continues to be made through advanced management techniques to reduce the average expense rate of individual policies. Individual insurance is a relatively small but important part of the health insurance business because it meets the needs of people who could not otherwise obtain all of the protection they desire.

The vigorous competition among hundreds of insurance companies and other types of insuring organizations assures that sound coverage is available at reasonable cost.

THE CONTROL OF COSTS AND QUALITY BY PRIVATE HEALTH INSURANCE

Insurance companies have promoted, and in many areas pioneered, the development of health cost and quality control procedures.

They have initiated and cooperated in a wide range of activities designed to:

*Upon enactment of the McIntyre Bill, with its recommended broader scope of minimum benefit standards, the average individual health insurance premium will be increased. Therefore, administrative expenses, as a percentage of premium, will be decreased.

- I. Identify and eliminate unreasonably inflated health care costs;
- II. Achieve optimum use of existing health care facilities and services;
- III. Increase provider productivity in the delivery of quality health care at reasonable costs:

I. IDENTIFY AND ELIMINATE UNREASONABLY INFLATED HEALTH CARE COSTS

A. Hospital costs

Hospitals have no effective control on the total budget of the institution. While hospitals have entered into a voluntary contractual relationship with Blue Cross and the federal government and state government for a major portion of their patient income, the revenue that is required to meet the original budget, which is excluded from the Blue Cross and government contracts, is obtained by shifting this burden to the insured and uninsured patient. This reimbursement pattern has not controlled costs but has forced hospitals to perpetuate present price inequities and discriminatory pricing practices.

Efforts by insurance carriers to control hospital costs would have to be based on a similar voluntary contractual arrangement. However, since insurance patients are the largest single source of the hospital's uncontrolled income, the hospitals have been unwilling to close this safety valve by negotiating similar contracts with insurance carriers. Furthermore, there are antitrust restraints on the business joining forces to negotiate with the hospitals as a unit.

The major public interest concern here is that the present reimbursement system has been largely ineffective as a brake against the continuing escalation in hospital costs for all third party sources, government, Blue Cross and insurance companies.

The most effective solution would be the enactment of state legislation establishing Rate Review Commissions to approve the rates for care rendered to all patients based on a prospective review and an evaluation of the hospital's total budget. The insurance business has sponsored such legislation in Massachusetts and has proposed its enactment in New Jersey and Pennsylvania. We are exploring the introduction of similar legislation in virtually all states.

This method of controlling hospital rates would substitute a single set of administrative criteria to be met in justifying costs in lieu of the multiple arrangements which are now required. It has been estimated that this change alone would reduce administrative costs for all patients by about 1 percent. This is an estimated savings of \$10 million in Massachusetts alone. The evaluation of departmental costs within a given hospital budget would be subject to peer judgment of individuals knowledgeable in hospital administration to determine where there are opportunities for introduction of cost saving management techniques compared to the national average. This practice, adopted on a limited basis in New Jersey, has reduced the rate of escalation by an additional 2 percent. Finally, there would be the requirement that capital costs of the institution which involve increased expenditures for expansion or modification in the facility would only be approved where they had been reviewed by the appropriate planning agency. This will eliminate inflation in hospital costs due to over-building and duplication of expensive services.

B. Physician charges

Virtually all existing methods of payment of physician's services fall into one of the following categories: (a) reimbursement based upon usual and customary fees; (b) fixed fee schedules; (c) voluntary agreement between the individual physician and a Blue Shield plan or insurance carrier to accept a fixed fee schedule for individuals within specific income levels; and (d) capitation or salaried arrangements.

The usual and customary fee reimbursement concept was developed by the insurance business under major medical coverage. It offers greater flexibility in enabling the carrier to cover a wide range of services subject to internal administrative measurements of what constitutes reasonable costs. Such coverage is generally administered so that fees which exceed a prevailing fee level for similar services rendered in the community are subject to further review by the company initially and frequently discussed with the physician to seek a reduction in the charge where it appears to be out of line. Where the carrier is unable to obtain reduction of a fee which appears to be excessive and the medical profession has established an effective peer review committee, the carriers will frequently refer the case to such committee for determination. While such committees do not exist

in every community and do not operate on a uniformly effective basis, some measurement of their value can be illustrated by the experience with one committee which has been functioning in the New York area for a period of 15 years, where the actual reductions have exceeded \$100,000 per year. However, the total savings due to the impact of the committee's work on fees in general is estimated to be in excess of a million dollars a year.

The early experience with peer review committees and their potential impact on both physician's fees and the "necessity" of the services rendered led to the interest of the insurance business in the medical and health care foundations developed by the medical profession.

The ability of the foundation programs to generate savings is illustrated by the first year of operation of the Foundation for Health Care Evaluation in the Twin Cities of Minneapolis-St. Paul. The general rate of escalation of physician's fees during this period was 2 percent in contrast with 5.2 percent for the nation as a whole.

The fixed fee schedule method of reimbursement has not been as flexible or effective as the usual and customary method of reimbursement. This is due to the fact that with physician's fees varying not only by geographical area, but within a geographical area, a fixed fee schedule must be established at a level which encompasses the services of most physicians in the area. This inflates the total cost since the physicians who are below the standard are automatically brought up to it. Conversely where the fee schedule is set too low, the number of physicians willing to serve patients at the subsidized fee is markedly reduced, creating problems of availability and accessibility of care.

In assessing the effectiveness of different methods of controlling the cost of physician's services, the major deficiency in the voluntary agreement between a participating physician and an insurance carrier or pre-payment plan, is the fact that it is generally limited to individuals and families below a specific income level. Thus, where the income of the insured individual exceeds the figure contained in the contract, the schedule payment is made as a partial reimbursement for the total fee with the participating subscriber or insured picking up the difference.

While the great bulk of physician's services are currently paid for on "fee-for-service basis" the insurance business is experimenting with capitation and salaried payments as part of their involvement in health maintenance organizations (HMO's) and prepaid group practice programs.

II. ACHIEVE OPTIMUM UTILIZATION OF EXISTING FACILITIES AND SERVICES

There is substantial evidence that most communities have an over-supply of acute hospital beds. As an example, the Kaiser Permanente Plan functions on the basis of two beds per 1,000, while most communities have a minimum of four beds per 1,000. Since it is axiomatic that "a built bed is a filled bed", it is apparent that the 50 percent lower bed population ratio is one of the underlying contributing causes of the 40 percent lower hospital use rate identified with the Plan.

The critical nature of this problem is underscored by the American Hospital Association identifying a cost of \$20 billion over the next five years for additional beds and modernization of existing obsolescent facilities. Thus, expansion may be planned in many instances where the community is already over-built.

Unless this issue is faced and resolved intelligently, we will have a multiplying cost impact on the system, not only in the initial cost of construction set between \$30,000 and \$40,000 per bed, but in the ongoing cost to the community of an estimated \$25,000 per year to maintain the bed—whether or not it is filled. Also to be considered is the resulting demand for increased manpower which is already in scarce supply, siphoning personnel off from critical areas where they might otherwise be used.

To meet this issue, the insurance business has worked with the medical care and health care foundations and has encouraged them to develop and expand current utilization control activities. These foundation activities are relatively new and in the early stages of development, but interest is expanding rapidly. The initial impact of this type of control is to depress occupancy levels in the institutions involved, reducing them to a more realistic level. The ability to reproduce such savings in the second year of the program is questionable, however, as there is no community measurement of what is actually needed; no way to convert surplus facilities to meet some other unfilled need; no way to control the future expansion of facilities and services in the area; and no way to

evaluate the institution's budget to prevent a simple reallocation of existing costs to a lower occupancy level.

Thus, after the foundation's utilization control program has brought occupancy levels down to a reasonable level, both the state and area-wide planning agencies would be requested to reassess their estimate of current bed needs for the community. The planning agency must be in a position to obtain compliance with its recommendations. The insurance business has supported and will support the enactment of "certificate of need" legislation in all states. At least 18 states have such laws.

The combined impact of expanded foundation activities together with the enactment of "certificate of need" and "prospective budget control" legislation will have a dramatic effect on costs, enabling existing surplus facilities to be converted where necessary to fill other facility or service needs identified by the planning agency. This will enable the community to avoid unnecessary hospital costs while increasing the availability and accessibility of care rendered in less expensive facilities. The result should establish a realistic basis for measuring future needs in facilities, services and manpower areas. Costly duplication of services would be eliminated and existing manpower resources would be conserved.

Individual company efforts to screen and control cases involving unnecessary utilization have included a number of experimental activities such as limited hospital certification programs, pre-admission testing programs, and the application of internal utilization guidelines. It should be recognized that the determination of what is "necessary" is solely a function of the physician's judgment in the management of the care of the patient. Thus, any unilateral action taken by the carrier after the care has been rendered simply reduces the insurance benefit payment and may leave the patient with the obligation to pay the difference. The "peer review" function of existing and new foundations have exerted a greater direct influence on physician's judgments during the course of treatment and offer greater opportunities for realistic controls.

When Congress enacted Public Law 89-749, the Comprehensive Health Planning Act, the insurance business developed its Health Insurance Council Community Health Action Planning Program (HiCHAP) to organize both industry and individual company efforts in support of this legislation. There are a minimum of 139 representatives of member companies of the Health Insurance Association of America serving on the advisory councils to the comprehensive health planning agencies established in each state and on the boards and committees of the regional areawide planning agencies.

A HiCHAP fund was created in the early days of this program to provide seed money grants to the newly emerging planning agencies. Liaison was established with the national, state, and local organizations concerned with planning.

The insurance business has participated in three demonstration planning projects in cooperation with the HEW in the cities of Miami, Florida; St. Louis, Missouri; and San Diego, California. These projects, which will be completed this year, have attempted to come to grips with specific health care problems in each community. It is hoped that the experience developed through these experimental projects will be of value to other planning agencies as they deal with similar issues.

In our opinion, certificate of need and prospective rate review legislation are essential to strengthen the planning process. Actions taken by individual third-party purchasers to provide a reimbursement incentive to the provider to accommodate to the planning agencies' recommendations are incomplete and ineffective answers to the problem.

III. INCREASED PROVIDER PRODUCTIVITY IN DELIVERY OF QUALITY CARE

The term "productivity" means increasing the capacity of the providers to produce more quality care at a reasonable cost level. There is current widespread interest in alternative delivery systems which will increase provider productivity. However, there are at present no objective criteria for evaluating the effectiveness of such competing systems. Such evaluation is fundamental prior to any decision to completely change the present system. Efforts in this area should be properly geared to first establishing what is a reasonable cost for each unit of service rendered both by institutional (e.g. hospitals) and noninstitutional (e.g. physicians) providers. The corollary question is whether the service performed conforms to a peer consensus as to what constitutes adequate quality care under normal conditions. Once we have established a reasonable cost for a unit of serv-

ice measured against a quality guideline, we can then determine the productivity of competing delivery systems in providing quality care at reasonable costs.

One method of carrying out such evaluations is through the medical and health care foundations which have developed screening guidelines for: (a) a measurement of a range of "reasonable charges for physician's services"; and (b) an identification of quality care, by diagnosis, for both ambulatory and institutional services.

The foundation thus establishes a basis for monitoring the delivery system with the cases falling outside of their guidelines subject to review and evaluation. Corrective actions may involve a reduction in the physician's fee where appropriate, reduce hospital stays, or point up wasteful practices as the focus of future education of physicians involved. Thus, the foundation does give us an opportunity to examine the present system, determine the things that require change, and offers a practical arrangement for influencing future practices which are controlled by physician judgments.

Insurance companies have also participated in experiments with prepaid group practice and HMO's to determine the impact of this method of delivery on the cost, productivity, and quality of care rendered, and to offer the consumer a dual choice option in obtaining and financing health care.

Insurance companies are involved in the operation or formation of prepaid group practice plans and HMO's in Columbia, Maryland; Boston; Nashua, New Hampshire; St. Louis; Philadelphia, Pennsylvania; Detroit; Washington, D.C.; New Haven, Connecticut; Boise, Idaho; Phoenix, Arizona; the Twin Cities; Wausau, Wisconsin; Chicago and in sections of New Jersey and California.

In summary, we are participating in an increasing range of experimental activities. While most of these activities are of relatively recent origin, they show great promise for building on the strengths of the present system and correcting its deficiencies. We view our primary role in these activities as one of representing the interest and concern of that portion of the population for whom we provide health insurance protection. Thus, we are seeking insurance representation on the newly emerging foundation boards and as non-voting consultants on their peer review committees. Similarly, we are seeking to expand our representation on the advisory councils to the existing comprehensive health planning agencies and on the committees and boards of areawide planning agencies. We are currently reassessing developments in the planning field since the original enactment of P.L. 89-749 to determine whether and how to strengthen this process. We will also be seeking representation on the advisory councils to the state agencies established to review and evaluate budgets and rates for institutional services and to implement certificate of need legislation.

THE REGULATION OF PRIVATE HEALTH INSURANCE

An extensive system of state regulation has been developed in this country, and refined over the years through Congressional mandate. Under this system insurance companies, to obtain and continue their licenses, must meet specified standards with respect to assets, reserves, and investments.

Each company must file annual financial statements, and be prepared for detailed periodic examinations by state insurance departments. These examinations cover not only a company's financial condition, but other facets of its operations that come under state statutory requirements. The results are a matter of public record, with state statutes providing for corrective measures in the event of financial weakness.

In addition, each company must file for approval both individual and group policy forms in every state; and in many states, the premium rates to be charged for such policies. If the forms are in any way unjust, unfair, inequitable, misleading, or contrary to law, they can be disapproved by the state insurance departments. For example, one basis for disapproval of individual policies would be proposed premiums that are unreasonable in relation to the benefits provided. Premium rates under group insurance must meet not only the competition between companies and among other types of plans, but also the review of management and labor.

Each state specifically provides under the State Fair Trade Practices Act that rates for any health insurance coverage cannot be unfairly discriminatory.

All states have enacted the Uniform Individual Accident and Sickness Policy Provisions which were adopted in 1955 by the National Association of Insurance Commissioners. These provisions relate to incontestability, grace periods, proofs

of loss, cancellations, uniform type size, claims procedure, and other provisions to protect the consumer.

Further guidelines for policy approval are contained in a Statement of Principles developed in 1948 by the National Association of Insurance Commissioners. This Statement calls in substance for keeping the number of policy forms within practical limits, the use of clear and direct language, properly worded insuring agreements, assurance of protection against substantial hazards, a clear definition of "limited" policies, policy names or titles that are not misleading, and other points to protect the public and provide orderly growth of the business.

In addition, all state insurance departments are set up to handle inquiries and complaints from the public, thus constituting yet another approach to protection of the consumer interest.

Steps to assure the fairness and clarity of policy provisions are matched by efforts to prevent misleading health insurance advertising.

There has been considerable controversy recently about the advertising methods employed in promoting certain types of health insurance policies. The National Association of Insurance Commissioners has developed Rules Governing the Advertisement of Accident and Sickness Insurance, as well as an Interpretive Guide designed to accompany the rules. The NAIC Rules provide a comprehensive approach to health insurance advertising and its enforcement. These Rules have been officially adopted in 33 States and are followed informally in the remaining 17. They have the strong support of this Association. In essence, the Rules call for advertisements to be truthful in fact and in implication. No misleading words, phrases, or illustrations should be used. All exceptions, reductions, or limitations should be disclosed, as should waiting periods and all policy provisions relating to renewability, cancelability, and termination.

Many other guidelines are set forth to protect the consumer, including appropriate use of testimonials and statistics; proper comparison of competitive policies; and true statements about claim settlements, enrollment periods, and the financial position of insurers.

It is, of course, incumbent upon companies to conform strictly with the NAIC advertising code, as with all state statutes that regulate the insurance business.

To keep direct mail insurance, which includes insurance sold through the mass media, in perspective, it would be well to note that this form of coverage represented only about 2 percent of the total health insurance premiums written by insurance companies during 1971.

Insurance companies support all reasonable efforts to raise the standards of state regulation. In this regard, it is recognized that each state has a responsibility not only to strengthen and enforce existing regulations but to help stimulate the necessary incentives for health insurers to continue to expand their markets and to design new and better coverages in the public interest.

Finally, it should be reiterated that competition among health insurers is, in itself, an important regulator of price and services.

In the area of cost control, the use of coordination of benefits provisions in group insurance policies discourages multiple coverages which may result in overinsurance. This provision prevents an individual having valid claims under more than one policy from receiving benefits in excess of 100 percent of his actual medical expenses and thereby making a "profit" on his illness. It thus discourages unnecessary utilization of medical services. This principle was worked out a number of years ago with insurance commissioners and the NAIC. It was recently reviewed and revised by that organization and has the approval of this Association.

THE FUTURE OF PRIVATE HEALTH INSURANCE

This brief review of the development and involvement of private health insurance over the past 30 years indicates that it has been, and continues to be, a viable and growing industry. It is an industry which is responsive to the changing needs and wants of the consumer.

The statement also indicates areas where we can do better. No enterprise, whether it be private or governmental, is without fault. There is always room for further improvement.

Over three years ago, our business became convinced that many deficiencies in the system required correction. As a part of that system we knew that there were some problems we could help correct, others we could not. It was apparent

that private health insurers could not do the whole job. There are segments of the population that cannot afford adequate coverage. Further, there are others who for various reasons do not choose to buy reasonably comprehensive coverage. Moreover, there are some people who found it difficult or impossible to obtain coverage because of their physical condition.

As we noted the rising public expectations for better care, and their concern about rising costs, we consulted with other segments of the health care system and began working on a program that would provide Americans with the opportunity and the means to secure better care. Our goal was to develop a program that would make possible a reoriented, better coordinated and more soundly financed system. We were guided by these principles: (1) a conviction that changes should be built on present strengths; (2) experimentation and flexibility should be encouraged; (3) the consumer should have freedom of choice in selecting among alternative means to better care; (4) the program of change should be a joint public-private enterprise.

It is our firm opinion that the Healthcare Program developed by our Association, the essential features of which are embodied in the "National Healthcare Act of 1971" (S. 1490) introduced by Senator Thomas McIntyre, provides an immediate, pragmatic solution to the problems which presently confront the delivery and financing of health care in this country.

Healthcare calls for:

Grants and loans for construction and start-up of ambulatory care facilities. Scholarships, grants, and loan programs for health personnel, and incentives for their practice in low-income areas.

A variety of cost and quality controls.

Effective comprehensive health planning, including a national Council of Health Policy Advisors.

Comprehensive health insurance benefits—nationally defined and standardized, and building on current group and individual plans to be phased in over a realistic period. These benefits would cover all forms of care—preventive, ambulatory, institutional, and catastrophic—and would be stimulated through Federal tax incentives.

Identical benefits for low-income groups, utilizing a system of state pool plans of private health insurers and financed in part through general revenues.

In summary, private health insurance has grown significantly over the past 30 years, both in terms of the number of people protected as well as the scope and breadth of its coverage. It has been administered at the lowest possible cost consistent with sound business practices. It has exerted a desirable influence upon the control of costs and the quality of health care, and programs now underway will do even more. It is supervised by a basically sound system of state regulation.

Private health insurance is an experienced mechanism. For more than 30 years insurance companies have been involved in financing, risk taking, administration, design of health benefit plans, marketing, enrollment, and claims costs processing and control—the very skills required to manage a national health care program. Moreover, our members are committed to a major role in serving the health system of the future. We urge that such a system be based upon the judicious blending of private and public enterprise.

We appreciate this opportunity to state our views.

HEALTH INSURANCE ASSOCIATION OF AMERICA—ACTIVITIES AND SERVICES

PURPOSE, FUNCTIONS AND ORGANIZATION

The Health Insurance Association of America consists of 326 insurance companies which are responsible for over 80% of the health insurance written by insurance companies in the United States today.

The general purpose of the Association is to assist its member companies in the promotion and development of voluntary health insurance for the provision of sound protection against loss of income and other financial burdens resulting from sickness or accidental bodily injury.

Its activities and services, described in more detail below, include:

1. The functions typical of other insurance trade associations, i.e., those involving State and Federal legislative and regulatory matters and those involving information, research and education, as respects health insurance. These functions are the responsibility of and are carried out directly by the Association.

2. The function, unique to the health insurance business, of maintaining liaison with, and furnishing information and technical assistance to national, state and local associations of doctors, hospitals, dentists and other providers of health care. This function is also the direct responsibility of the Association and is carried out in the name of the Health Insurance Council.

3. The public relations and information function for the health insurance business. This responsibility is discharged primarily through the Health Insurance Institute which operates as a division of the Institute of Life Insurance.

The activities and services of the Association, including the Health Insurance Council, and of the Health Insurance Institute are financed entirely by HIAA member companies. Funds are raised by annual assessments on United States health insurance premiums, under formulas which to the extent practicable give equitable recognition to the categories of activities and services outlined above and to the types and volume of health insurance written.

The policy of the Association is determined, and its affairs directed, by officers and directors who are senior company executives elected by the membership. Committees of member company officers furnish guidance to the Board of Directors and to the Association's professional and administrative staff headed by the President.

FEDERAL AND STATE LEGISLATION AND REGULATION

The interest of government at all levels in the regulation and supervision of the health insurance business has increased to a high degree in recent years with an accompanying increase in the number of legislative and regulatory proposals. A substantial part of the activities of the Association involve these areas.

1. The Association studies legislation and regulation and its effect on the health insurance business and reports to the membership.

2. The Association determines the views of its member companies on proposed legislation and regulation and presents these views before legislative and other governmental bodies. The Association also develops and seeks enactment of model legislation and regulation.

3. The Association maintains a close and continuing liaison with government at all levels, serves in a consulting capacity, and cooperates closely with government in both legislative and administrative areas, including representation before and liaison with the National Association of Insurance Commissioners.

4. The Association maintains an extensive bulletin service reporting on legislative and regulatory matters (see page 12).

5. The Association publishes and maintains two digests of laws and regulations (see page 13).

6. The Association furnishes information and assistance to member companies, as individually requested, in connection with policy drafting and approval requirements and other legislative and regulatory matters.

INFORMATION, RESEARCH AND STATISTICS

An important responsibility of the Association is to collect, and to evaluate and interpret, information and data which affect the health insurance business.

1. The Association makes studies and evaluates studies made by others, to assist the business to determine present and future courses of action. These studies deal with such subjects as the segments of the population without insurance or who are underinsured; coverages for extremely expensive forms of care such as heart transplants or kidney dialysis; coverages for nursing home, dental, drug, vision, and home care; mental illness; medical economic trends; and the relationship of insurance to prepaid group practice and health maintenance organizations.

2. The Association studies the health care delivery system and its relationship to the processes of health insurance. In so doing, it attempts to bring about needed changes in the delivery system, including those which would encourage the use of less costly forms of care.

3. The Association conducts regular and periodic statistical studies for the use of member companies at both the institutional and individual company level. Regular studies include an annual measurement of the number of lives insured for health care expenses and disability income as well as a quarterly survey of health insurance benefit payments. Periodic studies measure duplication of coverage, overinsurance, adequacy of coverage, and related matters.

4. The Association analyzes costs of legislative proposals and collects and interprets data for use in determining and presenting the Association's position on legislative and regulatory matters.

5. The Association provides information, liaison with, and technical assistance to universities, research agencies, libraries, the press, publications, managerial and labor groups, the providers of health care, and other groups having an interest in or related to health insurance.

6. In addition to specific studies and reports, information is disseminated to member companies through periodic bulletins (see page 12).

7. The Association staff prepares articles on the role of private health insurance in providing protection against the costs of illness and accident for publication in the insurance trade press, professional journals of the providers of medical care and business journals. Association staff members, to the extent practicable, speak before groups which are important to the health insurance business, and lecture in graduate schools of several universities.

EDUCATION PROGRAM

The Association sponsors a comprehensive program of health insurance study courses for Company personnel and others with an appropriate interest in learning the business. The program, consisting of basic and advanced courses in both group and individual health insurance, seeks to:

1. Demonstrate the value of pursuing a lifetime career in health insurance.
2. Create greater job satisfaction through a better understanding of the importance of health insurance to the economy.
3. Equip the student for more rapid achievement in his chosen field.
4. Provide an opportunity to broaden the students' potential in the insurance field.

MEETINGS

The Association holds two forums and an annual meeting each year—the Individual Insurance Forum in the Fall and the Group Insurance Forum in the Spring. The Annual Meeting is held in conjunction with the Group Forum.

The Forums provide an opportunity for company personnel at all levels of responsibility to exchange ideas and information on all aspects of health insurance operations and to learn of new developments. In addition to papers, addresses and panel discussions, wide use is made of the "workshop" technique, i.e., breaking up into small groups for informal discussion of particular subjects. The Annual Meeting provides an opportunity for company management to learn of and discuss, on a broader base, the problems and challenges of the business and the affairs of the Association.

The Health Insurance Council Division sponsors Regional Leadership Conferences, held in the Fall. These Conferences draw together selected representatives of the State Councils for a review of current major developments in the health care field, program priorities to be implemented at the state and local level, and to provide forums for practical exchanges on how to make the State Councils perform more effectively.

RELATIONS WITH PROVIDERS OF HEALTH CARE SERVICES (HEALTH INSURANCE COUNCIL)

The Health Insurance Council is a division of the Health Insurance Association of America, providing information and technical assistance on health insurance to the health care professions.

The Council is organized into five operating departments.

1. Community Health Planning—guiding and directing Council involvement in comprehensive health planning activities.
2. Institutional Services—dealing with relationships with hospitals and extended care facilities.
3. Professional Services—responsible for medical relations, dental relations, home care relations, pharmaceutical services, rehabilitation services, and allied professions.
4. State Councils—supervising the activities and programs in the field (through the State Council structure).
5. Uniform Forms—responsible for the development and promotion of Uniform Forms to expedite and simplify the payment of claims.

The operations of the Council are designed to :

Stabilize health care costs and improve quality by participation in programs under hospital, medical and community leadership. These programs involve the Council in a supportive role in the work of medical society review committees, hospital utilization committees, and planning for health facilities, services and manpower needs.

Improve communications between insurance and the providers of health care services by

(a) Establishment and maintenance of state councils (composed of insurance company representatives) which serve as a local point of contact with the providers of health care.

(b) Publications which provide a continuous flow of information to member companies and the health care professions. The Council publishes

—HIC Action—A report of national and field activities.

—HIC Viewpoint—Current comments on health insurance and the economics of health care.

—HIC News Briefs—A bimonthly report to company home office and field personnel who are involved in HIC activities.

—HIC Reports—Emanating from the Council's departments, reports are issued as needed, to provide information, guidance, reports of committee activities, etc.

—Annual Survey on the Extent of Voluntary Health Insurance Coverage in the United States.

—Annual Survey of Hospital Charges.

(c) Interpreting attitudes of providers of health care and planning agencies toward the insurance business and pointing up problem areas which are barriers to cooperation and understanding.

(d) Expediting referral and resolution of individual problems between companies and the providers of health care which have not been satisfactorily resolved at the local level.

PUBLIC RELATIONS (HEALTH INSURANCE INSTITUTE)

The Health Insurance Institute has the primary responsibility for the public relations and information program of the health insurance business.

The Board of Directors of the Institute is responsible for establishing the operating policies of the Institute, approving its programs and projects, and adopting its annual budget. Financing for the Institute comes from the member companies of the Health Insurance Association of America.

The Institute's Board consists of 20 members—the 10 members of the Public Relations Committee of the Health Insurance Association of America, and 10 who are appointed by the Board of the Institute of Life Insurance.

The Health Insurance Institute serves as a central source of health insurance information for the public on behalf of insurance companies, and reports public attitudes regarding this type of protection to the insurance business. The Institute has two main objectives :

1. To bring about a better public understanding and appreciation of health insurance policies and services offered by insurance companies ;

2. To inform insurance companies of public attitudes regarding their health insurance protection so that increased service to the public can be provided.

The operations of the Institute extend into many areas to inform the public and special groups on health insurance matters. In these continuing programs, the Institute :

—Releases news about health insurance written by insurance companies to newspapers, magazines and specialized periodicals. The principal vehicle utilized here is the Institute's monthly news release, "Health Insurance News."

—Assists editors, writers and researchers in preparing articles on health insurance for public consumption.

—Analyzes health insurance statistics of insurance companies for writers, economists, and others who evaluate for the public the social and economic effect of health insurance protection.

—Prepares educational material—such as films, filmstrips, booklets, and pamphlets—for the use of teachers, students, women's and other groups studying

health insurance and its value to the American family in budgeting for health care costs.

—Collects health insurance data and references for use by librarians, educators, students, and for the particular needs of other special public groups such as labor unions and employer associations.

The Institute has four annual publications, "Source Book of Health Insurance Data," "Group Health Insurance Policies," "A List of Worthwhile Life and Health Insurance Books" and "Health Insurance and Health Care Statistics," which provide both the public and the health insurance business with detailed factual and reference material on virtually all aspects of health insurance and health care.

The Institute also has developed a series of booklets and pamphlets to provide the public with specific information on health insurance and budgeting for the costs of health care. These include "The New ABC's of Health Insurance," "Our Family's Health Cost Record," "Understanding Our Health Insurance," and "Modern Health Insurance."

The Institute compiles for the information of the insurance business a weekly summary, "Editorial Round-Up," of news and commentary about health insurance from newspapers and other publications across the country.

ASSOCIATION BULLETIN SERVICES

To keep member companies informed on the latest developments in the health insurance field, the Association issues the following regular bulletins:

Legislative Bulletin—issued regularly during the legislative season giving a resume of state and Federal legislative measures when introduced and action taken; after adjournment giving a resume of new laws of interest and full text of new laws of special interest.

Insurance Department Bulletin—covers matters involving rules and regulations and notices of special insurance Department meetings or hearings, policy filing requirements, formal rules and regulations, and other general regulatory developments, including NAIC activities.

News Letter—brief bulletin of spot news, usually issued weekly.

Board and Committee Highlights—a "not for publication" report to members of the more important Board committee and subcommittee decisions, activities and recommendations. Issued bimonthly or as necessary.

Group Insurance Bulletin—covers matters related to or affecting group insurance which are of special interest or importance; information about Annual Group Forum.

Statutory Disability Bulletin—covers legislative, regulatory and administrative developments in the field of statutory disability insurance.

Individual Insurance Bulletin—covers matters related to or affecting individual insurance which are of special interest or importance; information about Annual Individual Forum.

Medical Economics Bulletin—covers matters related to the economics of financing medical care. Includes developments and trends affecting the cost of health insurance, experimental forms of health insurance, activities of other groups concerned with health services, and industry sponsored activities to improve relations with the providers of hospital and medical care.

Statistical Information Bulletin—covers actuarial and statistical information, including valuation studies, surveys on utilization and costs of medical services, morbidity statistics, and other surveys. Provides information with respect to changes recommended by NAIC for the annual statements.

Education Bulletin—covers matters related to the HIAA Education Program.

Special bulletins on subjects affecting health insurance and not covered in any of the above categories are issued as required.

ASSOCIATION PUBLICATIONS

Digest of Laws and Regulations—compilation of state laws and regulations pertaining to drafting, filing and approval of group and individual accident and health insurance policy forms and related matters.

Digest of Agents' Licensing Laws and Regulations—compilation of agents' qualification requirements; scope and limitations of such licenses and information relating to the business and conduct of agents, brokers and solicitors.

Handbook for Agents

Health Insurance Primer—study aid for agent's license exams; furnishes prospective agents with fundamentals of health insurance in question and answer form, covering agency laws and licenses, the application, uniform provisions, policy contract, claims and ethics.

Selling Health Insurance—outlines principles of selling health insurance; covers preparation for selling, prospecting, the approach, qualification and close.

Underwriting Health Insurance—outlines the fundamentals of underwriting from the viewpoint of the agent; covers the application, misrepresentation, physical and moral hazard, overinsurance and deductibles and coinsurance.

Monetary Values Based Upon the 1964 Commissioners Disability Table—a three volume set of active and disabled life reserves and net valuation premiums, calculated at 2½% and 3% interest rates, for use in the calculation of reserves for non-cancellable health insurance policies. The set is available at a cost of \$30.

Occupational Classification Report—four classifications.

Manual of Occupational Classifications—fourteen classifications.

These publications indicate the degrees of hazard pertaining to various occupations as same are related to risks in providing health insurance to individuals engaged in these occupations. They are based upon statistics gathered and compiled from widely distributed sources.

Standard Nomenclature List of Physical Impairments—1956—a code listing of physical impairments to facilitate the collection of exposure and experience data on specific impairments.

Statistical Plan for Individual Accident and Health Insurance—a system of securing and compiling basic data for individual health insurance statistical studies.

Partial List of Studies

Health Insurance and Prescription Drugs/1971.

Program for Healthcare in the 1970's/1970.

Health Insurance and Home Care/1970.

The Extent of Voluntary Health Insurance Coverage/1970.

Health Care Delivery in the 1970's/1969.

Health Insurance and Nursing Home Care/1969.

A Comparison of Group Medical Care Insurance Benefits to Charges/1968.

A Profile of Group Health Insurance in Force in the United States/1967.

Private Health Insurance/1967.

Role of Insurance Companies in Financing Hospital Care/1967.

Health Insurance and the Effectiveness of Health Care/1967.

Prevention of Loss and Rehabilitation/1963.

BOARD OF DIRECTORS

TERMS EXPIRING IN 1973

J.S. Bingay, Executive Vice President, The Mutual Life Insurance Company of New York

Robert A. McCord, President, Illinois Mutual Life and Casualty Company

R. Wesley Shope, President, Educators Mutual Life Insurance Company

Thomas A. Watson, President, The Lincoln National Life Insurance Company

David E. Watts, Vice President and Controller, Confederation Life Insurance Company

TERMS EXPIRING IN 1974

Gerhard D. Bleicken, Chairman and Chief Executive Officer, John Hancock Mutual Life Insurance Company

Dean W. Jeffers, General Chairman and Chief Executive Officer, Nationwide Mutual Insurance Company

Donald M. Johnson, President and Chief Operating Officer, Aetna Life & Casualty

C. J. Skelton, President, Republic National Life Insurance Company

Armand C. Stalnaker, C.L.U., President and Chief Administrative Officer, General American Life Insurance Company

TERMS EXPIRING IN 1975

Harry E. Atwood, President, Northwestern National Life Insurance Company

Morrison H. Beach, President, The Travelers Insurance Company

George L. Hogeman, President, The Paul Revere Life Insurance Company
 C. F. Schlueter, President, Employers Insurance of Wausau
 Rankin M. Smith, President, Life Insurance Company of Georgia

OFFICERS

Chairman: F. E. Rathgeber, Executive Vice President, The Prudential Insurance Company of America.

Vice Chairman: G. Preston Kendall, Chairman of the Board, Washington National Insurance Company.

Secretary: Stanford Miller, President and Chief Executive Officer, Employers Reinsurance Corporation.

Chairman of the Public Relations Committee: Jacque W. Sammet, President, CNA/insurance.

Chairman of the Health Insurance Council: Darwin S. Liggett, Senior Vice President, Special Services, Pacific Mutual Life Insurance Company.

Immediate Past Chairman: Harry V. Williams, Chairman of the Boards and President, The Hartford Insurance Group.

Mr. HENRY. Thank you, Senator. I know that you do have problems with the time, particularly this afternoon. While I had previously cut down the statement substantially, just at lunch Mr. Sharp asked that I see if I could do even better, which I have done. Now, I have cut out some more.

Senator HART. I think I should explain for the record, the length of this statement is a reflection of what we have asked of you. It wasn't your fault.

Mr. HENRY. Well, thank you, sir.

My name is Leslie Henry, and I am president of the Health Insurance Association of America. With me, on my right is John Hanna who is vice president and general counsel. On my immediate left Louis Orsini, director of the Health Insurance Council, and beyond him, David Robbins, director of statistics and control.

The association has 321 member insurance companies which are responsible for 84 percent of the health insurance written by insurance companies in the United States during 1971.

In the first two sections of my statement we provide data on the growth in the extent and adequacy of private health insurance over the past 30 years. In this connection I will just make two points; first, over 90 percent of the population of the country under age 65 have hospital coverage; and second, over 100 million have catastrophic coverage which varies in amounts from \$5,000 to now \$250,000.

Such growth clearly documents the service we provide to the public. For example, on the average about 80 percent of the health care charges incurred under group policies by our insured for items of health care they have chosen to insure are reimbursed through their policies. The statement gives greater detail about that. In many of the coverages the reimbursement is higher.

In the third section we note that our business is being administered at the lowest possible cost consistent with sound business practices.

For example, group plans are administered at 8 percent of premium, exclusive of taxes. This is for all group cases including the small ones. For a large plan we do it for 3 percent, which incidentally, is less than the cost of administering medicare. We feel very strongly that this is an impressive showing and that the cost of administering large plans is a much better comparison with medicare than with the OASDI program which is just a cash payment.

Now I turn to page 14.

Here we do deal with an issue that this committee has evidenced a great deal of interest in by their questioning—the control of costs and quality by private health insurance.

Insurance companies have promoted, and in many areas, pioneered, the development of health cost and quality control procedures.

They have initiated and cooperated in a wide range of activities designed to (1) identify and eliminate unreasonably inflated health care costs; (2) achieve optimum use of existing health care facilities and services; and (3) increase provider productivity in the delivery of quality health care at reasonable costs.

First, we deal with hospital costs.

While hospitals have entered into a voluntary contractual relationship with Blue Cross and the Federal Government and State government for a major portion of their patient income, the revenue that is required to meet the original budgets of these hospitals, which is excluded from the Blue Cross and government contracts, is obtained by shifting this burden to the insured and uninsured patient. This reimbursement pattern has not controlled costs but has forced hospitals to perpetuate the present price inequities and discriminatory pricing practices.

Since insurance patients are the largest single source of the hospital's uncontrolled income, the hospitals have been unwilling to close this safety valve by negotiating similar contracts with insurance carriers. Furthermore, there are antitrust restraints on the business joining forces to negotiate with the hospitals as a unit.

The major public interest concern here is that the present reimbursement system has been largely ineffective as a brake against the continuing escalation in hospital costs for all third-party sources, Government, Blue Cross and the insurance companies.

The most effective solution would be the enactment of State legislation establishing rate review commissions to approve the rates for care rendered to all patients based on a prospective review and an evaluation of the hospitals' total budget.

Our statement then describes the anticipated cost effectiveness of this legislation and I am now moving over to page 16.

With respect to physician charges. Virtually all existing methods of payment of physician's services fall into one of the three following categories: (a) reimbursement based upon usual and customary fees; (b) fixed fee schedules; (c) voluntary agreement between the individual physician and a Blue Shield plan or insurance carrier to accept a fixed fee schedule for individuals within specific income levels; and (d) capitation or salaried arrangements.

The usual and customary fee reimbursement concept was developed by the insurance business under major medical coverage. It offers greater flexibility in enabling the carrier to cover a wide range of services subject to internal administrative measurements of what constitutes reasonable costs. Such coverage is generally administered so that the fees which exceed a prevailing fee level for similar services rendered in the community are subject to further review by the company initially and frequently discussed with the physician to seek a reduction in the charge where it appears to be out of line. Where the carrier is unable to obtain reduction of a fee, which appears to be

excessive, and the medical profession has established an effective peer review committee, the carriers will frequently refer the case to such committee for determination.

Skippping the balance of that paragraph.

The early experience with peer review committees and their potential impact on both physician's fees and the necessity of the services rendered led to the interest of the insurance business in the medical and health care foundations developed by the medical profession.

The ability of the foundation programs to generate savings is illustrated by the first year of operation of the Foundation for Health Care Evaluation in the Twin Cities of Minneapolis-St. Paul. The general rate of escalation of physician's fees during this period was 2 percent in contrast with the 5.2 percent for the Nation as a whole.

We then point out the disadvantages of fixed-fee schedules and voluntary agreements on schedules and mention our experiments with capitation and salary arrangements.

And at the bottom of page 19 we give our answer to the utilization issue. To meet this issue the insurance business has worked with the medical care and health care foundations and has encouraged them to develop and expand current utilization control activities. These foundation activities are relatively new and in the early stages of development, but interest is expanding rapidly. The initial impact of this type of control is to depress occupancy levels in the institutions involved, reducing them to a more realistic level. The ability to reproduce such savings in the second year of the program is questionable, however, as there is no community measurement of what is actually needed; no way to convert surplus facilities to meet some other unfilled need. No way to control the future expansion of facilities and services in the area; and no way to evaluate the institution's budget to prevent a simple reallocation of existing costs to a lower occupancy level.

Thus, after the foundation's utilization control program has brought occupancy levels down to a reasonable level, both the State and areawide planning agencies would be requested to reassess their estimate of current bed needs for the community. The planning agency must be in a position to obtain compliance with its recommendations. The insurance business has supported and will support the enactment of "certificate of need" legislation in all States.

At least 18 States have such laws. I understand that figure is now 20 States.

The combined impact of expanded foundation activities together with the enactment of certificate of need and prospective budget control legislation will have a dramatic effect on costs.

Turning now to health planning on page 21, the middle of the page.

When Congress enacted Public Law 89-749, the Comprehensive Health Planning Act, the insurance business developed its health insurance council community health action planning program. Hichap for short, to organize both industry and individual company efforts in support of this legislation. There are a minimum of 139 representatives of member companies of the Health Insurance Association of America serving on the advisory councils to the comprehensive health planning agencies established in each State and on the boards and committees of the regional areawide planning agencies.

I have given Mr. Sharp a copy of this list.

A Hichap fund was created in the early days of this program to provide seed money grants to the newly emerging planning agencies. Liaison was established with the National, State, and local organizations concerned with planning. The insurance business has participated in three demonstration planning projects in cooperation with the HEW in the cities of Miami, St. Louis, and San Diego, Calif.

These projects which will be completed this year have attempted to come to grips with the specific health care problems in each community. It is hoped that the experience developed through these experimental projects will be of value to other planning agencies as they deal with similar issues.

Coming now to increased provider productivity on that same page.

The term "productivity" means increasing the capacity of the providers to produce more quality care at a reasonable cost level. There is current widespread interest in alternative delivery systems which will increase provider productivity. However, there are at present no objective criteria for evaluating the effectiveness of such competing systems. Such evaluation is fundamental prior to any decision to completely change the present system.

Continuing now on page 23.

One method of carrying out such evaluations is through the medical and health care foundations which have developed screening guidelines for: (a) a measurement of the range of reasonable charges for physician's services; and (b) an identification of quality care, by diagnosis for both ambulatory and institutional services.

The foundation thus establishes a basis for monitoring the delivery system with the cases falling outside of their guidelines subject to review and evaluation. Corrective actions may involve a reduction in the physician's fee where appropriate, reduce hospital stays, or point up wasteful practices as the focus of future education of physicians involved.

Thus, the foundation does give us the opportunity to examine the present system, determine the things that require change, and offers a practical arrangement for influencing future practices which are controlled by physician judgments.

Insurance companies also have participated in experiments with prepaid group practice and HMO's to determine the impact of this method of delivery on the cost, productivity, and quality of care rendered and to offer the consumer a dual choice option in obtaining and financing health care costs.

We then mention our involvements with HMO's and summarize our cost control activities which takes us over to page 27.

A brief description of the system of State regulation appears on the pages I have just omitted. Part of that description deals with the advertising rules that you talked about in previous hearings, and now I only want to direct your attention to one paragraph on page 27, a little past the middle.

To keep direct mail insurance, which includes insurance sold through the mass media—and these mass advertisers—in perspective, it would be well to note that this form of coverage represents only about 2 percent of the total health insurance premiums written by insurance companies during 1971.

As our efforts to the future, this brief review of the development and involvement of private health insurance over the past 30 years indicates that it has been, and continues to be, a viable and growing industry. It is an industry which is responsive to the changing needs and wants of the consumer.

The statement also indicates areas where we can do better. No enterprise, whether it be private or governmental is without fault. There is always room for further improvement.

Over 3 years ago, our business became convinced that many deficiencies in the system required correction. As a part of that system we knew that there were some of the problems we could help correct, others we could not. It was apparent that private health insurers could not do the whole job.

There are segments of the population that cannot afford adequate coverage. Further, there are others who for various reasons do not choose to buy reasonably comprehensive coverage. Moreover, there are some people who found it difficult or impossible to obtain coverage because of their physical conditions.

Our goal was to develop a program that would make possible a reoriented, better coordinated and more soundly financed system. It is our firm opinion that the health care program developed by our association, the essential features of which are embodied in the National Healthcare Act of 1971 (No. 1490), introduced by Senator Thomas McIntyre, provides an immediate, pragmatic solution to the problems which presently confront the delivery and financing of health care in this country.

Healthcare calls for: Grants and loans for construction and start-up of ambulatory care facilities; scholarships, grants, and loan programs for health personnel, and incentives for their practice in low-income areas;

all variety cost and quality controls; and
effective comprehensive health care planning, including a national Council of Health Policy Advisers.

Comprehensive health insurance benefits—nationally defined and standardized, and building on current group and individual plans would be phased in over a realistic period. These benefits would cover all forms of care—preventive, ambulatory, institutional, and catastrophic—and would be stimulated through Federal tax incentives.

Identical benefits for low-income groups, utilizing a system of State pool plans of private health insurers and financed in part through general revenues.

In summary, private health insurance has grown significantly over the past 30 years, both in terms of the number of people protected as well as the scope and breadth of its coverage. It has been administered at the lowest possible cost consistent with sound business practices. It has exerted a desirable influence upon the control of costs and the quality of health care, and programs now underway will do even more. It is supervised by a basically sound system of State regulation.

It has earned the privilege to continue to serve the American public.
Thank you, Senator.

Senator HARR. Thank you, Mr. Henry.

You, I think, have helped us by excerpting from page 27 here, that one paragraph. You remind us that the mail order business is just 2 percent of the total health business.

Mr. HENRY. Right.

Senator HART. What is your own opinion as to the role the mail order business should play?

Mr. HENRY. Well, as has been covered many times in the hearings, these plans in general provide supplementary benefits. So long as the public really understands that these are not substitutes for basic coverage or comprehensive coverage and all of the advertisements and all sales pitches are honest and the people can understand them, then we see no reason why they should not be permitted to continue.

Senator HART. I won't be unkind, by asking you the name of the company that meets the test you just described, unless you want to volunteer one.

Mr. HENRY. I think as a trade association person that I appreciate your understanding, Senator.

Senator HART. I confess that I am not at all comfortable on one point you make that I think may lead us to quarrel. If people who are solicited, understand the limitation of the coverage and what is meant, fine. They can make their decision based on an informed presentation.

But earlier testimony gave us the profile of the customers of one such company, and clearly, by reason of age, education, income levels, they make up the very segment of the public which is most likely to be confused, the least likely able to be discerning and selective.

I shall not ask your opinion, but I have a feeling that few among this group know what we mean when we talk about supplemental and are least likely to understand the terms of the contract and, because of their place in the general social scheme of things, are most subject to the fears of menaces of illness, and the consequences, economically speaking.

Do you have members from mail order?

Mr. HENRY. We do have members who do insurance by mail order and various forms of it. We do have a section in the prepared statement that deals in some detail with the efforts the association has made, particularly in cooperation with the National Association of Insurance Commissioners, the NAIC, to improve this situation.

Now, Mr. Hanna, our general counsel, has been very close to all of those developments, and if you would care to have him tell you about those efforts and activities, I am sure he would be happy to do so.

Senator HART. Fine.

Mr. HANNA. We agreed that the objective here is for the insured to understand his coverage, and we recognize, Senator, that the very people who want this coverage may be the ones who will be most difficult to make understand.

On the other hand, we believe that a company can follow the NAIC rules carefully—and there are those companies—I agree with Mr. Henry that it is not appropriate for us name a company or name it and thereby implying that others do not follow the rules. Companies which do carefully follow the NAIC rules for advertising, as amended by the NAIC just 6 months ago with specific reference to the mass media advertising.

We believe that such advertisements can convey to the insured a very clear, or as clear as possible, picture of what coverage is provided. If the word supplemental is not clear, we might use the words meant to be purchased in addition to your other basic coverage, which is the substance of a phrase sometimes now used.

There may have to be further work along this line, but I think by using the printed word with care and by working with the NAIC, good advertising can be developed which will cause people to understand their coverage to the extent possible.

We recognize that most of us probably don't understand what we are going to get or not get from social security or a lot of other programs. We cannot expect perfection, but we can work in that direction.

I think a perusal of the work that has been done indicates real sincerity on the part of a great majority of companies to advertise fairly and completely.

Senator HART. Supplementals—assuming now that the purchaser understands the language—represent, at least in the mind of that purchaser, an opportunity, perhaps the only opportunity, to obtain something important to the purchaser and not available under basic contracts. Is that right?

Mr. HANNA. Not necessarily not available, but perhaps in addition to the basic contract, which the purchaser may have. The coverage may be in addition to medicare. It may be in addition to a group policy or in addition to some other individual policy.

The main thing is for him to understand what the policy covers; that it pays only when he is in the hospital if that is the fact; that it pays not \$600 a month which is \$20 a day, so it is in terms that the customer can understand easily.

Senator HART. To the extent then, whether it is medicare or something else, to the extent that that is more broad rather than less broad, you reduce the need for supplemental?

Mr. HANNA. I expect you do, but I really know of no program that has been devised which would not produce some need and undoubtedly some desire for some supplemental coverages.

Senator HART. So we conclude that when making that buying decision, it is important the individual know what he has and know what it is proposed that he buy?

Mr. HANNA. Yes, sir.

Mr. HEMRY. Yes, sir.

Senator HART. And you do not have to limit yourself to those then with less than a high school education. We have identified a great many people who have problems with both of them?

Mr. HANNA. Yes, sir.

Senator HART. In the prepared statement you say there is a widespread interest in alternative delivery systems which will increase provider productivity and so on.

And you point out there are, at present, no objective criteria for evaluation of the effectiveness of the systems. Yesterday or the day before—and you may have heard the testimony or read it—Dr. Romer of the UCLA med school and a public health physician gave us a summary of a 7-year study he and his associates had made.

That study seems to indicate that while the commercial health insurance industry obtained the best risks, the Blues the middle level of

risks, and the greatest—as distinguished from the best risk—winds up in the group practice.

That study suggests that the cost, when you take premium charges plus out-of-pocket charges, is heaviest for the commercial insurance, at least for the group. And having defined what elements he included to make the judgment as to what the quality of care is, that study suggested that the best care was obtained through the group practice, and the last satisfactory through commercial.

Now, how do you react to that study?

Mr. HEMRY. Yesterday was the first time that I had ever heard—or any of our people had heard—of this study. I did hear the testimony.

I therefore feel completely unable at this point to comment on the validity of the methodology and on the conclusions drawn.

The professor said that in a month or so he would have a 100-page summary report, and then later a complete report of several hundred pages. I would think that at that point our statisticians could examine the report. Then we could come to some conclusions.

I was very interested in his study and in his figures. We will be very interested in examining it with great care to see just where we do come out.

The other thing I would say is this: Our association and the commercial insurance companies, are working very hard in a very broad way in this field of HMO development.

Many of our companies are involved importantly in many of these HMO's throughout the country. And we, on a very broad basis, are making dual choice options available to present policyholders so that, to the extent that these conclusions are sound, we are moving right ahead to encourage this development.

We have appeared before both the Senate Health Subcommittee, and the House Subcommittee on Public Health and the Environment, saying that we are doing these things; we are trying to move ahead; and we are not waiting.

So to that extent and the extent that his conclusions are sound, we are going ahead. I am inclined to think that as these spread the real proof of the pudding is going to be how they develop and stand up.

But I just would not feel capable of commenting at this point on his study, as such, and on his conclusions.

Senator HART. I think it is more responsible for you to reserve comment, giving the massive data that must be behind that subject and giving you an opportunity to evaluate that, rather than tackling it now.

Mr. Sharp?

Mr. SHARP. Thank you, Senator.

Mr. Hemry, the Health Insurance Association of America was asked to supply and they did supply a list of names of agents and company personnel, regional officers, and field directors, et cetera, who are associated with or have representatives on the comprehensive health planning agencies in the States, the so-called *A* and *B* agencies.

I note that you make passing reference here, in your full statement to the comprehensive health planning agencies and the Hichap program.

You say there is a minimum of 139 representatives of the member companies of your association serving on the advisory councils to the comprehensive health planning agencies.

Now, I would like to get certain background information into the record here, to put this all in perspective. Six years ago Congress established comprehensive health planning on a State and areawide or local basis.

The Federal Government under a matching grant program puts up 50 percent of the money to both the 314(a) State agencies and the 314(b) areawide or local comprehensive health plan, and the States match the funds for the State plans, and a mixture of private and public funds, depending on local law, match the funds for the areawide plans.

In essence, comprehensive health planning is an outright admission that marketplace economics—competition, supply, and demand—are not operating efficiently and sufficiently with respect to health care resources.

The Federal Government has stepped in to see if it can help do this. It was deemed a partnership—I believe it was called a partnership for health care resources.

Mr. ORSINI. A partnership for health care programs.

Mr. SHARP. A partnership for health.

Recently, before the Institute of Medicine on May 10, 1972, Secretary Richardson stated:

Today all States and territories have comprehensive health planning agencies and more than 170 local and areawide agencies now serve about 70 percent of the Nation's population.

By the way the law establishes these comprehensive health planning agencies providing that there must be 51 percent or more consumer representation. I would like to read just a little bit more of what Secretary Richardson had to say.

He said:

From their inception these agencies have been underfunded and understaffed. Even more pertinent, they have not had any real authority to coordinate planning.

One of the Secretary's conclusions was:

Ultimately, we may conclude that to provide adequate health care we are simply going to have to invest a great many more dollars. Just as no amount of money is likely to help solve our health care problems in the absence of sound planning, so no amount of planning can be expected to solve these problems without a commitment of sufficient resources.

It is my understanding, in reading your testimony, and from other literature we have received from the Health Insurance Association and from the Health Insurance Council, that you have been fairly active over the years in comprehensive health planning, both the *A* and the *B* agencies; is that correct?

Mr. HENRY. That is correct.

Mr. SHARP. In fact, it is my understanding—and please correct me if I am wrong—a gentleman by the name of Arthur Browning of the New York Life Insurance Co., who is a vice president, serves on the comprehensive health planning organization task force for the city of New York.

Is that still so?

Mr. HEMRY. Yes.

Mr. SHARP. Is he in charge, basically, is he the man who shall we say assumes the leadership to move this thing for Hichap?

Mr. HEMRY. May I interrupt right here, and say that Mr. Orsini is the director of the Health Insurance Council.

The Health Insurance Council is a division of the Health Insurance Association of America. It is a part of our organization. It was set up to be concerned with and to deal with relationships with hospitals, doctors, nurses, and the various providers of care.

Mr. Orsini is much better informed in the area of Hichap and these other areas of control of costs of medical care than I am. I would like to turn this discussion over to Mr. Orsini.

Mr. SHARP. I will direct my questions to—is it Mr. Orsini?

Mr. ORSINI. Orsini.

Mr. SHARP. Thank you. Mr. Browning still, then, is in charge. I mean, he is the member of the company who is in charge of the program?

Mr. ORSINI. Mr. Browning is chairman of our community health planning committee, which is one of several departments in the Health Insurance Council Division.

Mr. SHARP. In this piece of paper here, a photostatic copy of the actual document submitted to HEW in the granting application, he was nominated by the Health Insurance Association of America. And he is listed as a provider representative.

Mr. ORSINI. That's correct. In that instance, but there are insurance representatives on other advisory councils, who are participating as consumer representatives, they are carry—

Mr. SHARP. Do you know Mr. Larry Newell?

Mr. ORSINI. Yes.

Mr. SHARP. He is associated with your program?

Mr. ORSINI. He was associate director in charge of the planning department, working under my direction.

Mr. SHARP. Were you at a conference in St. Louis, Mo., on October 15, 1970?

Mr. ORSINI. No; I was not at that conference. I believe Mr. Newell was, though. That was one of our predemonstration planning projects.

Mr. SHARP. Mr. Newell stated at that conference on October 16 that:

Comprehensive health planning was in a crisis—a crisis for survival. It is up to the community level if the partnership for health is to survive. It requires a concerted action on the part of public, private, and government.

Later one of the representatives stated that:

Community health planning may spend most of their energies in trying to stay alive, when there are relatively few dollars that are needed.

It has been said, as to these area B plans that although some insurance company money had come into them originally, they are literally starving for funds to match the Federal grants. This was one reason for Secretary Richardson's comments.

Do you have any comment on that?

(Document follows. Testimony, resumes on p. 1325.)

MEMORANDA OF CLAUDIA B. GALIHER OF HEALTH SERVICES AND MENTAL HEALTH
ADMINISTRATION. OCTOBER 20, 1970

Subject: Attendance at St. Louis, Mo. Meeting on Financing of CHP, October 15-16, 1970.

(Notes on Discussion on Friday, October 16, 1970.)

"Mr. Phillips (Chicago) indicated that after getting the presidents of the major insurance companies together to discuss funding problems, Chicago had received a grand total of \$750 from each."

"Jacksonville :

Federal grant-----	\$84,000
Total budget-----	170,000
City of Jacksonville-----	35,000
Chairman of Council, Indiana Life Insurance (approximately)-----	25,000
Prudential-----	2,000
Blue Cross (same to Miami)-----	2,500
Contractor-----	1,000
Hospital council-----	¹ 5,000
Medical society-----	¹ 500-1,000
Other insurance-----	¹ 2,000-3,000

"Phoenix :

Federal grant-----	\$50,000
Local government-----	10,000
Additional special study on burn and trauma-----	10,000
Special study (hospital)-----	3,000
Blue Cross and Blue Shield-----	5,000
Health Insurance-National-----	1,000
Individual hospitals-----	10,000
Medical society-----	1,000
Voluntary health agency-----	2,000
Labor-----	1,500
Local industry-----	1,000
National industry-----	2,000

"Chicago :

Federal grant-----	\$338,000
Total budget-----	650,000
Medical society-----	18,000
Hospital-----	18,000
Cook County Board of Health-----	10,000
Chicago Board of Health-----	16,000
Northeast Illinois Plan-----	30,000
Welfare Council-----	16,000
Blue Cross-Blue Shield-----	18,000
Chicago Community Trust-----	12,500
Foundation-----	10,000

"Atlanta :

Federal grant-----	112,000
Local government-----	112,000
Hospital district-----	10,000
Blue Cross-----	2,200
HICHAP-----	1,000

¹ Purchase order, emergency medical care, \$2,500.

"Larry Newell (formerly of HICHAP) indicated that CHP was in a crisis—a crisis for survival. It is up to the community level if the Partnership for Health is to survive. It requires a concerted action on the part of Public-Private-Government."

"Mr. Newell indicated that he felt it reflected on the partnership which isn't working."

"CHP may spend most of their energies in trying to stay alive (raising funds) when there are relatively few dollars that are needed."

"Milt Gans and we are playing games. If we're really trying to change the system (social and health) funds are not going to come from the local level. If local funds must be raised and used in the next 50 years, nothing will happen."

Mr. ORSINI. I would agree with Secretary Richardson's observations. I think the problems confronting planning, they are understaffed, they are underfinanced, and they have no way to enforce their responsibilities.

As far as our progress in relating to those problems, we thought the way to give them authority was through certificate of need legislation stipulated in our statement. As far as financing, the understaffing, we looked at the problems. The original concept of these agencies is that they could be expected to perform a job assigned to them and do it on a basis in which once a year they are required to go around and solicit funds from the community for a voluntary basis.

It required reevaluation it seemed to us. We think the basic financing concept of comprehensive planning ought to be preexamined.

On that, of course, we feel that in the interim we have to encourage our companies to assume their share of the operating budgets of these agencies, and we have attempted to do so.

Mr. SHARP. Is it not a fact the insurance industry as a whole has put very little money into the area B plans?

Mr. ORSINI. We do not know. As you well know, we had the original seed grant fund which was terminated in 1970.

At that point we undertook to transfer this responsibility to the companies, and have them make their contributions individually in each community.

We do not have an accurate reading of how much money was generated or contributed. I think the question of whether there was a lot contributed or a little contributed is a matter of relevancy. I cannot give you an actual, factual figure.

Mr. SHARP. We will introduce into the record some samples taken from the HEW files showing the contributions to various area B plans.

Senator HART. It will be made a part of the record. (See pp. 1360-1369.)

Mr. SHARP. The law states that 51 percent will be consumers.

Mr. ORSINI. I think the original intent involved 51 percent with consumer control.

Mr. SHARP. That is what the law says, is that not correct?

Mr. ORSINI. Yes.

Mr. SHARP. What is your feeling as far as getting innovative organization, delivery, and financing of health care where providers can be shown to be in control, not consumers on a State or local basis? What is your reaction?

Mr. ORSINI. You have got to remember, in establishing the responsibilities of these agencies, the point was made that they have no clout? You have an advisory council to the agency, which is advisory to the head of the comprehensive health planning agency, which was appointed by the Governor.

However, the decision is made by the head of the comprehensive health planning agency.

You have, at the areawide level, a mix of community interests, with the idea of 51 percent consumer involvement. Incidentally, the approval of the board as to whether or not it does in fact represent 51 percent consumers is a function of the B agency making recommendations to the A agency. Ultimate approval rests with the regional office of HEW.

So we still have, however, at the regional level an advisory function being performed, an advisory function as to whether or not the needs and priorities of that community in terms of their manpower, facilities and services resources are adequately being taken care of.

That recommendation is, again, submitted to the head of the "A" agency, and he takes final action on the issue.

Mr. SHARP. In Fort Smith, Ark., the areawide "B" agency plan, its health planning executive committee has five consumers, ostensibly, and four providers. Now, there was a Mr. Paul Schaefer from Fort Smith, Ark., listed as a consumer, and he is executive director of the Arkansas Medical Society.

That would shift this committee to five providers and four consumers. I assume that in most States the medical society representatives are listed as providers.

Mr. ORSINI. Again, I want to repeat that the responsibility for approval of the distribution of the board, providers and consumers, is a function of the regional office of HEW. It is based upon the recommendations of the "B" agency to the "A" agency and then on to the regional office.

Mr. SHARP. We understand that. Now, in Tucson, Ariz., for example, on the "B" agency health planning council's executive committee there is a Mr. William Alberts, Jr. Again, we have a situation of a health planning council of seven members, four of whom are ostensibly consumers and three providers. Mr. William Alberts is listed as a consumer, and it states in his bibliography that his term ends in 1973, and that:

The Health Insurance Council (HIC) although it has no office in Tucson, has designated Mr. Alberts as its local representative. Because of his general community concern for the problems of reimbursement for health services, and because of his knowledge of and contacts in health insurance, Mr. Alberts was selected to represent the health insurance industry.

Further on in this bibliography it shows that Blue Cross representatives are listed as providers. We have gone through these—and I am not going to take the time, Mr. Chairman, now. We would like to introduce into the record the number of instances where Health Insurance Council members are listed as consumers.

Now, do you feel that this complies with the intent of the statute?

Mr. ORSINI. First let me make the distinction between Blue Cross and insurers as to why Blue Cross might always be construed a provider.

You must recognize that in most Blue Cross plans there is very heavy involvement of hospital administrators on the board. You must recognize that Blue Cross does have a contract with the hospitals where in many instances, the hospital coinsures their liability in the event of insolvency. So that the basic ties between Blue Cross and the provider, I think, would tend to produce that kind of consistency.

As far as our involvement is concerned, I view our involvement as fundamentally that of manifesting the interest and the concern of the consumers who we insure. I see no conflict of interest in the objectives of the planning statute initially in terms of expanding the availability and the accessibility of health care resources with this consumer and provider decision or line of demarkation, as far as our interest is concerned.

We feel we can relate to the public interest issue very clearly.

Senator HART. I would ask you to yield to Senator Gurney.

Mr. SHARP. Yes, sir.

Senator GURNEY. Thank you, Mr. Chairman.

I notice in your statement that you refer to the numbers that are insured in this country under various health insurance plans. I think it is about 100 million, as I recall, in one instance.

Do you have any idea of how many complaints you get from your consumers that have health insurance plans, insured by private industry over a year?

Mr. HEMRY. I certainly could not give any estimate of that. We know there are some. They come to—as somebody was saying earlier in the hearings—somebody who has a complaint not infrequently they write to the president of a company. They think that will get attention, and, as a matter of fact, it does.

I used to answer those letters for the president of a company I was associated with, and he saw them.

If they are still unhappy, or sometimes in the first instance, they will write to the insurance commissioner. And then it gets back to the company.

Yes, sir; there are complaints. There is no question about it. But the magnitude of it, as compared with this 100 million who have catastrophic coverage and the 170 million who have hospital coverage, well, I know it would be a very tiny fraction. But what it would be, I don't know.

Senator GURNEY. It is a fact, I take it, that over the years—and I think you mentioned in 1951, some of this health insurance, again, there has been a tremendous increase in volume and sale of private health insurance coverage. Has there not?

Mr. HEMRY. Oh, yes. There is really a phenomenal growth. I think in one draft of this statement we said the growth is not matched by any other business. We decided that might be an overstatement, but it might not have been. We took it out. But it has been a phenomenal growth.

Senator GURNEY. It tends to indicate there certainly is a general acceptability among consumers in this country of private health insurance coverage.

Mr. HEMRY. It seems so to us.

Senator GURNEY. I have one or two questions here on your statement.

Page 14, on this part about health costs, I must say I do not understand that first paragraph. I read it over. I just do not understand it.

Could you explain that to me?

Mr. HEMRY. Senator, I am delighted that you brought it up. I am going to pass the buck again to Mr. Orsini. But when you were asking your question about what health insurance industry has done to control the costs of medical care, we squirmed in our seats because we really wanted a chance to answer that question.

Mr. Orsini, I think, can do it a good deal better than I, so I will ask him to respond.

Mr. ORSINI. Senator, may I clarify the paragraph that you are referring to? It is the one under the heading, "hospital costs"?

Senator GURNEY. Yes.

Mr. ORSINI. Well, I think the best way to understand it is to recognize that the hospital recovers, at the present time, more than 95 percent of its operating income from patient sources.

The patient sources are made up of Blue Cross subscribers, Government beneficiaries, whether they have medicare or medicaid, people who are insured, and people who are uninsured.

Now, the basic problem stems from the fact that a hospital has a total budget which reflects its operation and the credibility of its operations. However, it recovers this total budget from these multiple sources.

Now, while we have negotiated relationships, voluntarily entered into between the hospital and Government, between the hospital and Blue Cross, the fact is that as long as they have a source of uncontrolled income, the effect of any negotiated cost reimbursement arrangement does not exert any control over that total budget. If they do not recover it from Blue Cross or medicare, they recover it by shifting the burden to the patient who pays charges. That is a combination of the uninsured and insured.

So we think that the point that was made earlier—and I think it has been made several times throughout this discussion—as to whether competition exerts any control on hospital costs, this clearly demonstrates that it does not. It produces fragmentation and gaps in reimbursement, which eliminates any control on the total budget.

So we are saying, when it comes to holding a hospital accountable for its operations, there should be a one-time negotiation in which all third party sources as identified are represented around the same table. It should not be retrospective, where the hospital has the opportunity to increase its costs and then pass them on.

But it should be prospective, and that we should be able to look at that budget before they can change their rates, so we have a greater predictability of cost.

And we say, too, that at the point where the negotiation is faced there are three fundamental issues to be resolved. The first is: "What are your costs?" A uniform system of cost identification is needed. There is money wasted now because the various third party sources all have independent methods of establishing the answer to the same question.

The second question is: "Of your costs, which should properly be recovered from patients as opposed to nonpatient sources?" We think, again, there is only one principle that should override here. If the service which the hospital is providing for the community is needed and it is not clearly financed from some other source of nonpatient income, then it should clearly be charged to all patients in the same way.

The third question is: "Are your costs reasonable?" And at this point we think there is a need and there is an absence right now of the opportunity for peers in the field of hospital administration to look at a given department's costs, and say:

Since we are comparing you with this hospital over here and you are both providing similar services, we think you could do a lot better job, and would do even better if you adopted this additional cost-saving technique which has been proven in this hospital.

We think that there are real economies behind this concept of prospective budget control.

Senator GURNEY. On that point, how would you suggest that that be handled most effectively?

Mr. ORSINI. Let me tell you how it has been done in New Jersey, where they are applying this concept on a limited basis. They have set up an advisory committee. On that advisory committee there were doctors, hospital administrators, and consumers.

And the evaluation of the elements of the budget is subject to not only professional review, but the input of the consumer. And it is surprising how many opportunities for economy have been uncovered, as demonstrated by the fact that they were able to reduce the rate of escalation on this point alone by 2 percent.

Senator GURNEY. Is that done under New Jersey State law?

Mr. ORSINI. Yes. Right now it is not as comprehensive as we would like it to be. We would like to change it so the impact can be spread to all patients.

Senator GURNEY. Do many other States have this kind of law?

Mr. ORSINI. At the present time there is one other State that has this kind of law. That is Maryland. The 3-year disclosure period is there so the impact of this legislation has not yet been felt.

We are sponsoring legislation in Massachusetts which is currently before the legislature. We have requested that it be introduced in Pennsylvania and in New Jersey on a large scale basis. We are attempting to raise the issue in other States, even if it means we have to get out in front.

Senator GURNEY. I had a question here. The last one I have. Are regulations State or Federal?

Since we are on this discussion, let's get to that now. Do you think State regulations or the kind you talk about are sufficient and effective? Or do you think Federal regulation would be better?

Mr. ORSINI. We are handicapped by the lack of complete experience. The principle of State regulation, we think, is a valid principle.

However, we think you could perhaps examine the position taken by the American Hospital Association at their last meeting with the house of delegates where, in effect, they were suggesting that Federal legislation to facilitate the expansion of these rate review commissions in accordance with certain common criteria.

So that may be an area for you to explore further.

Senator GURNEY. Perhaps if we could do it as in the area of air pollution, we established minimum standards, although we do not prevent States from going beyond that if they want to.

Mr. ORSINI. I think that is the intent for certain uniform criteria applied here which would permit them to do it.

Senator GURNEY. Go on. I did not mean to interrupt you.

Mr. ORSINI. That is all right.

Senator GURNEY. I thought maybe you had not finished.

Mr. ORSINI. I am finished.

Senator GURNEY. On page 17 you talk about this foundation for health care evaluation in Minneapolis and St. Paul. Could you describe that a little more, what is the foundation? Is that a private foundation?

Mr. ORSINI. No. What it is, as a matter of fact, we would be very happy to furnish you after the hearing is over with a current "Viewpoint" which details this operation today, that "Viewpoint" being one of our publications.

It is an organization of doctors, with the board controlled by doctors, but with consumers involved, with third parties involved, with the planning agencies involved, with management and labor, as well as hospital administration.

The intent was to set up a structure for monitoring the delivery of medical care in that community in accordance with cost criteria, quality criteria, involving the question not only of appropriate care, but what is medically necessary and unnecessary.

It has only been in operation 1 year. They have learned a great deal, we think. We think that they have done a very effective job on the fee control issue. We think they have isolated problems in terms of making the quality control work, while it has not yet worked well, they are moving in that direction.

We think it offers very realistic possibilities for influencing physician judgments in such a way, through this process of monitoring and evaluation. The idea is that in order to look at the things that are wrong with the system, you must isolate them by applying the criteria as to reasonableness of costs, the necessity of the type of care rendered in terms of quality criteria. Having sifted out that information, you look at those cases.

Then you make your evaluation as to whether or not it was justified.

The fee issue—the doctors who are participating, and 92 percent of them are, have agreed to be bound by the judgment of their peers, and some of them have had their fees reduced.

The most significant figure, though, we think in the whole area to date, and we hope it continues, has been as you look at the control of the cost of doctors' fees, there are two elements. There is the problem of taking care of the fee which exceeds the prevailing fee guideline in that community, and they are able to do that.

But there is a much larger issue of depressing the general rate of escalation in fees. The first year that this program operated, the general rate of escalation—under a system where doctors set their own fee level, but there was a monitoring system, and the process was being applied by their own peers—the general rate of escalation was 2 percent as opposed to better than 5 percent for the Nation as a whole.

This was a very significant saving we think.

Senator GURNEY. What about hospital costs now as far as this foundation is concerned?

Mr. ORSINI. The way the foundation has approached the hospital cost problem is to say initially that control of hospital costs is not their function.

However, with this multidiscipline board, those of us who sit on the board except to bring that issue up for review and evaluation, because we think the community shares an interest in this question of how we hold the hospital accountable for its operation.

That happens to provide a good forum for doing it with the responsible elements of the community in the picture at the same time.

Senator GURNEY. You are going to explore it, as I understand, and possibly recommend legislation later on?

Mr. ORSINI. And possibly take the initiative ourselves. We think everybody ought to be aware of what is going on. Consistently, you talk to the hospitals first about our interest in legislation, and sometimes we find they are willing to support the principle, because they do see it coming.

I think it is important that they figure out how to live with the new reimbursement pattern.

Senator GURNEY. How did the foundation idea get started in Minneapolis-St. Paul?

Mr. ORSINI. I think the idea came about largely as a result of the concern of the leadership group within the profession who could see the pressures building around. They could see the prospects. They could see the fact that a doctor could no longer relax on the question of how he delivers care.

Now, it was a very small segment—the leadership group. But they were fortunate in that they had the confidence of their associates, and they have been able to maintain this confidence so far.

We see that in an awful lot of other communities now, there are six others in the development stage now, and there are 30 now looking at the question. I do not want to overstate that, because it is clear that, as doctors get closer to this question of an effective monitoring system, some of them become nervous.

On the other hand, we see much more widespread interest than ever before. And our real goal is to look all the options over, and if we can find something that works better, we want to try it. We want to become involved.

Senator GURNEY. Is this just in Minnesota?

Mr. ORSINI. It is operated only in the Twin Cities now. In Hartford, Conn., we have one that will be getting off the ground around the fall of this year. There is one in the process of development in Seattle, one in Iowa, Missouri, and in San Antonio, Tex. We consider them second-stage programs.

We are involved in exploratory discussions with another 14 States at the moment. So that it is clear, the interest this area is expanding.

Senator GURNEY. There is mentioned on page 18 of this Kaiser plan, which has utilized hospital beds in a more efficient way than the average in other communities.

How do you account for that? Can you explain that a little bit more?

Mr. ORSINI. I think what we are trying to illustrate is that there are right now wide discrepancies between the kind of organization that the Kaiser plan represents and the system as a whole.

This is one of the discrepancies—the fact that Kaiser is organized to deliver their care on the basis of two beds per thousand, and most communities have four. Obviously, an inflationary cost influence.

What we are saying is that whether it is two or four, the optimum level is probably somewhere in between. But on top of this we have a planned expansion to go beyond four in many communities. We think that rather than starting to expand, what we need to do is to implement this utilization control which the foundations are beginning to develop so that we find out whether it should be two or four.

And then we should plan for expansion, once we have reduced occupancy to the optimum level.

Senator GURNEY. Has the Kaiser plan worked under this average of two beds per thousand?

Mr. ORSINI. I think it has. I think their statistics in terms of reducing hospital use are clear. We say there is a correlation between bed availability and use. If you have 50-percent less beds available, you have lower utilization.

Senator GURNEY. I gather that. But did they use any better methods of bed utilization?

Mr. ORSINI. Of course they have other things, I think, which are not characteristic of the system as a whole. They do cover outpatient services right across the board. They have a comprehensive program. In many plans we have outpatient coverage but in some we do not.

They have the opportunity to exert a direct impact on the budget and the kind of efficiency that is built into their hospital operations. In most communities we do not have that option.

Yes, Kaiser is doing a good job. I think nobody would debate that. The real problem is how do we reproduce the advantages of the Kaiser arrangement in the system as a whole.

That is where the problem becomes more complex.

Senator GURNEY. Any ideas on that? I guess that is the question I should have asked.

Mr. ORSINI. Well, we are trying to suggest one way of doing it. We should encourage foundations to develop a sensible basis for monitoring what is going on in the community as a whole.

If in monitoring and applying utilization controls it becomes apparent that you are overbedded as a community, we have a way of dropping the bed availability through effective planning. If it becomes apparent that the hospitals in that community have really ignored opportunities for improved efficiency, the budget review will give you a chance to get a handle on that problem.

We think we have a mix of responsibilities. The main point is how do we coordinate all of these pieces so that in the final analysis we are reproducing the things that are good about competing systems, or at least finding a way to test the ability to reproduce them.

Senator GURNEY. One final question. This is a question I asked this morning about hospital costs, how to keep them down, how to get a handle on them.

You have talked about many different ways here, including voluntary self-policing. Again, I ask the question: How best do you think we can get on top of it?

Obviously, it is a mix of private industry and of government. Which is the best way to handle it in any way?

Mr. ORSINI. I think if you look at the pieces as a whole, if you are going to hold the hospitals accountable for their budget, I think we have to do it through commissions, we have to find a way to expand their development.

If you are going to exercise some control of the physician's judgment who, after all, does determine when you need hospitalization, how long you keep patients there, you have got to bring what he is doing under some process monitoring and of peer evaluation. And we have to have objective third parties with a window on that process.

We believe it helps the credibility of the end result.

Finally, we have to recognize we have given the planners a large area of responsibility, but we have not given them the clout. We have to give them, through certificate of need legislation, the authority to enforce the decisions that are reached at the planning process at the local level.

I think the mix of those three things will give us a great deal more to look at, offer great opportunity for progress, greater than we have now.

Senator GURNEY. Thank you.

Senator HART. That was very helpful.

Mr. Sharp?

Mr. SHARP. No further questions.

Senator HART. There is a passage in the early part of your statement. Now, I do not want to end today on a depressing note. This is not intended that way, but I want to get this thing in a little better focus.

You refer to the evolution of dramatic growth of coverage over 20 years ago. Insurance companies saw the need to cover costs of medical care outside the hospitals, protection against the large expenditures of illness. In 1951 this coverage, major medical expense insurance, covered 108,000 people. It went to 76 million under 65 by the end of 1970.

Blue Cross and Blue Shield and other prepaying plans were developing this same protection. You say—

When their enrollment is added to insurance company coverages, we find over 100 million Americans with catastrophic expense protection against costs incurred both in and out of the hospital, including the costs of treatment for mental illness and prescribed drugs.

I wish I could agree that was literally true, because that would be a bright note on which to end. And it would give me the understanding that each of those more than 100 million Americans is covered against medical catastrophe.

Do you believe that?

Mr. HENRY. Yes, I do. Of course, it depends on your definition of catastrophe.

Senator HART. It sure does.

Mr. HENRY. And that varies according to income level. We do have in the statement—I believe it is in here—some figures which showed the percentage of costs paid by these catastrophe or comprehensive plans, at the \$5,000, the \$10,000, and \$50,000 level.

Quite recently, one of the major companies announced a plan with limits of \$250,000 for major medical and, certainly, that would cover almost anybody's catastrophe. There would be very few cases over that.

However, I think really—these plans are doing a good job there, and are paying a very high percentage of the costs of these catastrophies.

However, the real answer—and I would like to end on a happy note, too, and suggest that the real answer to the problem is a national health insurance plan along the lines of Senator McIntyre's bill. That certainly would make insurance available to every American, regardless of income, and would provide truly comprehensive coverage phased in over a period of time, so we do not overload the system with demand that it cannot supply.

That is really the basic start to the answer to these problems.

Snator HART. Well, the language I cited to you could suggest, if you read it literally, that the basic need has been answered for more than half the people in this country right now. And it is that which I question.

I agree, we may be playing with the definition of catastrophe. Clearly we are.

Given my impression of the coverage now available—not available but rather the coverage which is held, I would have to define your use of catastrophe as meaning one that is not a full-blown catastrophe. We have no feeling in this area that more than half of the people in this country, which would be the case with over 100 million Americans, now have coverage that would protect them from catastrophic health problems, both in and out of hospitals.

Mr. HENRY. I do not want to presume upon your time, but these figures were developed by Mr. Robbins. He has not had a chance to participate in our discussions.

Senator HART. Maybe you could give us your definition of catastrophe as used in this paragraph.

Mr. ROBBINS. I agree with a lot of what you said, Senator. I think everyone's definition of catastrophe will differ, depending on his individual circumstances.

I would like to add one additional fact, and that is that some of the claim studies we have done indicate that a little under one out of a thousand persons in this country last year had medical bills in a given year of \$5,000 or more.

For that one in one thousand that had \$5,000 in bills, even a medical policy with a \$5,000 maximum would have helped him solve his problems.

Mr. CHUMBRIS. Mr. Chairman?

Senator HART. Mr. Chumbris.

Mr. CHUMBRIS. I have one question which was referred to me by a Senator's office other than a member of this committee. May I ask it?

Senator HART. Certainly.

Mr. CHUMBRIS. It will only take a few seconds.

This is the issue in a drug prescription program, negotiated between a union and an industry through an insurance carrier. The local pharmacies complained that this was price fixing and restraint of trade in that pharmacies could not bargain, but must take the price of the drugs offered.

The pharmacist has nothing to say, even though the price is to his detriment.

Have you had that matter brought before you? This has been going on for several years, because the Congressman called me several years ago on exactly the same point.

Mr. HENRY. Mr. Chumbris, I have heard about that program. I think perhaps it is the UAW program that many companies are involved in.

I would be reluctant at this time to attempt to answer it. If you care to, however, we will be happy to prepare a response for the record.

Mr. CHUMBRIS. That will be fine, Mr. Chairman. That would satisfy the inquirer.

HEALTH INSURANCE ASSOCIATION OF AMERICA,
Washington, D.C., June 29, 1972.

Hon. PHILIP A. HART,
U.S. Senate, Committee on the Judiciary, Subcommittee on Antitrust and Monopoly, Washington, D.C.

DEAR SENATOR HART: During our recent appearance before the Senate Subcommittee on Antitrust and Monopoly, Mr. Chumbris inquired about prepaid pre-

scription drug programs and whether our Association has looked into this matter. As you may be aware, these prescription programs have been the subject of an inquiry by the Subcommittee on Environmental Problems Affecting Small Business to the House Select Committee on Small Business and a report of that panel (House Report No. 92-683) was issued last November.

That report describes a prepaid prescription drug plan as a program "for reimbursement directly to a contract member pharmacy for the cost of the drug plus a fixed fee for the pharmacist's professional services in filling the prescription." The description continues by stating that the "method of determining costs and fixed fees varies considerably from plan to plan, although in most instances these methods are set forth in a contract between a member pharmacy and the insurance carrier, or plan administrator."

On July 9, 1971 Bruce B. Wilson, Deputy Assistant Attorney General for Consumer and Interagency Affairs, Department of Justice, presented the Department's views to the House Subcommittee on the development of such plans with particular emphasis on the antitrust implications involved. We also recognize that there are significant antitrust problems involved in these arrangements. Consequently, the various committees of the Association, and our staff, have refrained from becoming involved either directly or indirectly in this area. Thus, insofar as the role of the Association is concerned these plans are purely private arrangements between individual insurance companies, their policyholders and the individual pharmacies involved, and not an area for trade association participation.

Respectfully yours,

LESLIE P. HENRY, *President.*

INSURANCE COMPANY REPRESENTATION ON SEC. 314(a) HEALTH PLANNING ADVISORY COUNCILS TAKEN FROM
COMPREHENSIVE HEALTH PLANNING REPORTS AS OF 1971

[Insurance company people listed as consumer (C) and provider (P) membership in Health Insurance Council (HIC)]

State	Number	P or C	HIC
Alabama	2	C	
Arizona	1	P	Yes.
Colorado	1	P	Yes.
Connecticut	2	P	Yes.
District of Columbia	1	P	Yes.
Hawaii	1	C	Yes.
Iowa	1	P	Yes.
Kansas	1	C	
Louisiana	1	P	Yes.
Maine	1	P	
Massachusetts	1		
Minnesota	3	C	
Nebraska	1	P	Yes.
New Jersey	2	C	
New York	1	C	Yes.
North Dakota	1	C	Yes.
Oklahoma	1	C	Yes.
Ohio	1	C	Yes.
Oregon	1	C	Yes.
Utah	1	C	
South Dakota	2	C	
Tennessee	2	C	
Vermont	1	C	Yes.
Wisconsin	2	C	

FT. SMITH, ARK. HEALTH PLANNING EXECUTIVE COMMITTEE

Dr. George W. Allen, President, Provider.
 Bob McCuistion, President Elect, Provider.
 Dr. Charles I. Hughes, Secretary, Provider.
 J. D. Martin, Waldron, Consumer.
 Larry Randall, Fort Smith, Consumer.
 Harold Oakes, Ozark, Consumer.
 Mrs. Paul X. Williams, Booneville, Consumer.
 Lawrence Wewers, Van Buren, Provider.
 Paul Schaefer, Fort Smith, Consumer.

HEALTH PLANNING ADVISORY BOARD CONSUMERS

Name	Title	Address	County
Mr. J. D. Martin.....	Funeral director.....	Martin-Rice Funeral Home, P.O. Box 428, Waldron, Ark. 637-2167	Scott.
Rep. George Nowotny.....	State representative.....	1st Federal Bldg., Fort Smith, Ark. 783-5193.	Sebastian.
Mr. Harold Oakes.....	County extension agent.....	P.O. Box 77, Court House, Ozark, Ark. 667-3720.	Franklin.
Rev. A. J. Parrish.....	Minister.....	900 North 9th St., Fort Smith, Ark. 782-0688.	Sebastian.
Mr. George Porter.....	Labor representative.....	1112 North 21st, Fort Smith, Ark. 782-2635.	Do.
Mr. Larry Randall.....	Retail business.....	Randall Ford, Inc., 5500 Rogers Ave., Fort Smith, Ark. 452-1311.	Do.
Mr. Reginald Saucier.....	Owner-manager restaurant.....	Shed Restaurant, Highway 71 South, Waldron, Ark. 637-7407.	Scott.
Mr. E. W. Savage.....	Realtor.....	20 North Broadway, Booneville, Ark. 675-3320.	Logan.
Mr. Paul Schaefer.....	Executive director.....	Arkansas Medical Society, P.O. Box 1208, Fort Smith, Ark. 782-8218.	Sebastian.
Mrs. Nancy Wenderoth.....	Housewife.....	5703 Kinkead, Fort Smith, Ark. 452-1320.	Do.
Mrs. Paul X. Williams.....	Housewife.....	P.O. Box 326, Booneville, Ark. 675-3281.	Logan.
Consumer.....	To be added.....		

BRIEF BIOGRAPHICAL SKETCH OF COUNCIL MEMBERS

Name: Paul C. Schaefer—Consumer.

Occupation: Executive Vice-President of Arkansas Medical Society.

Formal Education: B.S. in Business Administration, University of Missouri.

Civic Activities and Organizations: Former member of Board, Salvation Army; active in Congressional Action and other committees of local Chamber of Commerce; has served a number of years as treasurer of Fort Smith Rotary Club; Executive Secretary, Medical Education Foundation for Arkansas.

Remarks: Good attendance, active, outspoken.

THE CITY OF NEW YORK, COMPREHENSIVE HEALTH PLANNING—ORGANIZATIONAL TASK FORCE

BIOGRAPHICAL STATEMENT

Arthur Browning, 96 North Woods, Manhasset, N.Y., Residing in New York City 36 years.

Occupation: Lawyer.

Employed by: New York Life Insurance Company, 51 Madison Avenue, New York, N.Y.

Title: Vice President.

Nominated by: Health Insurance Association of America, 750 Third Avenue, New York, N.Y.

TUCSON, ARIZONA

For the purpose of recommending major changes in County-provided mental health services.

CONSUMERS

William Alberts, Jr.; term ends 1973.

Manager of Investment Department, Arizona Insurance & Investigation Corp., P.O. Box 12489, Tucson, Arizona 85711. Home address: 414 East Glenn Street.

The Health Insurance Council (HIC), although it has no office in Tucson, has designated Mr. Alberts as its local representative. Because of his general community concern for the problems of reimbursement for health services, and because of his knowledge of and contacts in health insurance, Mr. Alberts was selected to represent the health insurance industry.

Mrs. Barbara Altman; term ends 1973.

Committee for Economic Opportunity, 721 North Fourth Avenue, Tucson, Arizona 85705. Home address: 8526 East 35th Street.

Mrs. Altman is Director of Planning, Evaluation and Technical Assistance, of the Committee for Economic Opportunity, the Community Action Program for this area. She was elected to board membership because of her level of technical information as well as to strengthen Health Planning Council's relationship with the broad spectrum of Office of Economic Opportunity-sponsored programs.

Michael S. Borozan ; term ends 1971.

City of Tucson, Office of the City Council, 69 North Meyer Avenue, Tucson, Arizona 85701, Home address : 2730 North Norris Avenue.

Mr. Borozan is a City Councilman of the City of Tucson. He was elected to the board upon the nomination of the majority of the Mayor and Council to succeed the previous City of Tucson representative, Councilman Richard J. Kennedy. Mr. Borozan is a teacher at Tucson High School.

SUMMARY OF BOARD COMPOSITION

The Health Planning Council board of directors is composed of 37 persons, of whom 22 are consumers and 15 are providers. The proportions, then, are 59 per cent consumers and 41 per cent professional.

Ethnic-racial minorities are directly represented by four members of the board. However, it should be noted that the interests of and concern for minorities and the poor have further representation on the board through additional members of agencies such as Model Cities, Committee for Economic Opportunity and Pima County Hospital Consumer's Council, all of whom have continuing interactions with Health Planning Council.

Criteria Assuring Broad Health and Consumer Representation

Each major socio-economic segment of the community is represented by a consumer on the board of directors and on the standing committees on HPC. When a vacancy occurs another representative of that segment is invited to fill it. The same mechanism is used to assure that all major components of the health care delivery system are represented. The consumer-provider ratio is hereby also maintained.

The current officers of the Health Planning Council are:

President, Oscar A. Thorup, M.D., Provider.

Vice President, J. Luther Davis, Consumer.

Secretary, Mrs. Julia C. Soto, Consumer.

Treasurer, Frank R. Guthmann, Consumer.

The officers named above and the following three board members comprise the Executive Committee:

William Alberts, Jr., Consumer.

Frederick J. Brady, M.D., Provider.

Donald G. Shropshire, Provider.

COMMUNITY SERVICE COUNCIL, INC., COMMUNITY HEALTH PLANNING COMMISSION

BIRMINGHAM, ALABAMA

(P)—Provider 33.

(C)—Consumer 34—Includes the people in insurance business.

Chairman: Wm. H. Manly.

Co-Chairman: Frank Dominick.

Rev. H. W. Anthony, (C), Minister, Bethel AME Church, 1423 Avenue K, Ensley, 35218 (785-8779).

T. J. Barefield-Pendleton, M.D., (P), 801½ Brighton Avenue, Roosevelt City, Alabama, 35020. (425-0941).

Harold Benson, Administrator, (P), Peoples Nursing Home, P.O. Box 1012, Jasper, Alabama, 35501 (384-9086).

Chester W. Black, Administrator, (P), Shelby Memorial Hospital, Alabaster, Alabama, 35007. (663-0711).

C. Preston Blanks, Jr. (Ex Officio) (P), Health Planning Administrator, Alabama Advisory Council for Comprehensive Health Planning, State Office Building, Montgomery, Alabama, 36104. (269-6376).

Robert W. Block, President, (C) National Woodworks Inc., P.O. Box 5365, 35207. (252-7157).

John Bloomer, (C), The Birmingham News, 2200-14th Avenue, North, 35203, (325-2210 (Off.) 325-2209 (Direct)).

Joel S. Boykin, D.D.S., (P), 2723 29th Avenue, North, 35234 (324-7531).

Donald C. Brabston, (C) Ernst and Ernst, First National Building, 35203, (323-6371).

H. Dale Brown, M.D., (P), Baptist Medical Center, 800 Montclair Road, 35213, (591-2304).

W. C. Browne, M.D. (P) Vincent, Alabama, 35178 (672-2401).

Joe Bruno, President, Bruno Food Stores, 2620-13th Street, West, 35208 (786-5251).

- John L. Carmichael, M.D. (P) 2011-9th Avenue, South, 35205 (252-6141).
 Glenn K. Cole, (C) Birmingham Labor Council, 1712-7th Avenue, North, 35203 (328-5866).
 Gordon Craven (C), Parrish, Alabama, 35580 (686-7721).
 Frank Dominick (C), Dominick, Fletcher, Yielding & Dominic, Brown Marx Building, 35203 (322-0653).
 E. B. Glenn, M.D. (P) 1025 South 18th Street, 35205 (933-7071).
 Leon C. Hamrick, M.D. (P) Lloyd Noland Hospital, Fairfield, Alabama, 35064 (785-2121).
 Georg E. Hardy, Jr., M.D., M.P.H. (P) Health Officer, Jefferson County Department of Health, P.O. Box 2591, 35202 (324-9571).
 Paul A. Henderson, O.D., (P), Jefferson County Optometric Assn., P.O. Box 204, Bessemer, Alabama, 35020, (415-2401).
 Tillman Hill, Administrator, (P), Burdick-West Memorial Hospital, Haleyville, Alabama, 35565, (486-5213).
 Leroy Holt, M.D., (P), 316-17th Street, North Bessemer, Alabama, 35020, (425-1035).
 Duane T. Houtz, Administrator, (P), Baptist Med. Center, Montclair, 800 Montclair Road, 35213, (592-0081).
 L. T. Hudgins (Retired), (C), Alabama Power Company, 506 Glen View Drive, Jasper, Alabama, 35501, (384-4153).
 E. O. Jackson, (C), Birmingham World Newspaper, 312 North 17th Street, 35203, (251-6523).
 Joe James, Attorney, (C), Haleyville, Alabama, 35565, (486-2224).
 Mrs. A. L. Jasper, (C), Guidance Director, Miles College, Vinesville, Alabama, 35208, (786-5281).
 Harry Jeffcoat, Jr., (C), Central Bank Building, 35203, (251-9221).
 Robert J. Juster (Ex Officio), (C), Director, Regional Planning Commission, Room 1524, 2121 Building, 2121-8th Avenue, North, 35203, (251-8139).
 Mrs. Anna M. Kirksey, (C), 608 Country Club Drive, Roosevelt City, Alabama, 35020, Work : 428-9383 or 425-9418.
 William M. Lawson, D.M.D., (P), 1914-13th Avenue, South, 35205, (933-1392).
 Ralph T. Lyerly, (P), Northway Nursing Home, 1424 North 25th Street, 35234, (328-5870).
 Mrs. Annie Goree Madison, (C), 590-41st Street, North, 35222, (251-3819).
 Hobson Manasco, M.D., (P), Haleyville, Alabama, 35565, (486-5255).
 William H. Manly, Vice President, (C), Southern Services, P.O. Box 2641, 35202, (879-2231).
 Mrs. John Massey, R.N., (P), P.O. Box 1, Locust Fork, Alabama, 35097, (681-9746).
 Sam L. Maury, (C), Assistant to Vice Pres.-South, U.S. Steel Corporation, P.O. Box 599, Fairfield, 35064, (783-2117).
 Mrs. Francis Maxwell, (C), 2204-6th Terrace, North, 35203, (322-0909).
 Charles A. McCallum, M.D., D.M.D., (P), Dean, School of Dentistry, U. of A. Medical School, 1919-7th Avenue, South, 35233, (934-4534).
 Mrs. William C. McDonald, (C), 2201 Crest Road South, 35209, (933-0753).
 William E. Miller, (P), Blue Cross-Blue Shield of Alabama, 930 South 20th Street, 35205, (328-S111).
 Charles W. Neville, M.D., (P), 2714-31st Avenue, North, 35207, (323-2526).
 John M. Packard, M.D. (Ex Officio), (P), Bessemer, Alabama, 35020, (425-2274).
 Mrs. Olive Pierce, R.N., (P), 910 College Avenue, 35209, (788-6581).
 Robert Price, Blount Ct. Health Dep., (P), 307 5th Street, North, Oneonta, Alabama 35121.
 Rev. George Quiggle, (C), Greater Birmingham Ministries, 107 South 20th Street, 35205, (251-5208).
 Olen Roy Ratliff, (C), State Farm Insurance Co., 223½ 2nd Avenue, E., Oneonta, Alabama 35121, (274-2123).
 Larry B. Richmond, (P), Crestline Heights Pharmacy, 60 Church Street, 35213, (871-0317).
 Hardin M. Ritchey, M.D., (P), Hill Crest Hospital, 7000 5th Avenue, South, 35212, (592-8976).
 *Mrs. Frances B. Russey, R.N., (P), Dir., Bureau of Public Health Nursing, Jefferson County Dept. of Health, 1912 8th Avenue, South, 35233, (324-9571).
 *Robert V. Sanders, Administrator, (P), Hill Crest Hospital, 7000 5th Avenue, South, 35212, (836-7201).

Harris Saunders, Sr., (C), Saunders Leasing System, Inc., 201 Office Park Drive, 35223, (879-2131).

Sheldon Schaffer (Ex Officio), (C), Chairman of Health Research Committee Head, Economic Research & Planning Sect., Southern Research Institute, 2009 9th Avenue, South, 35205, (323-6592).

James E. Sharman, Ed. D., (C), University of Alabama in B'ham, 1919 7th Avenue, South, 35233, (934-5322).

John M. Slaughter, M.D., (P), Chairman, Jefferson Co. Bd. of Health, Lloyd Noland Hospital, Fairfield, Alabama 35064, (785-2121).

S. L. Stigler, M.D., (P), 924 South 18th Street, 35205, (933-8028).

H. P. Turner, (C), Route 4, Box 269H, Cairo, Bessemer, Alabama 35020, (425-7808).

John E. Walker, (C), Walker Plywoods, Inc., 1139 1st Avenue, South, P.O. Box 332, 35233, (252-9861).

Barney Weeks, President, (C), Alabama Labor Council, AFL-CIO, 1018 South 18th Street, 35205, (933-8956).

M. E. Wiggins, President, (C), Birmingham City Council, City Hall, 710 No. 19th St., 35203, (323-5431).

David Williams, M.D., (P), 808 Orchard Road, Jasper, Alabama 35501, (384-4330 or 387-2902).

Louis J. Willie (Ex Officio), (C), Executive Vice President, Booker T. Washington Insurance Co., P.O. Box 697, 35201, (328-5454).

W. Paul Yeager, (C), Planning Director, Shelby County, Route 2, Civil Defense Bldg., Columbiana, Alabama 35051, (669-6091).

Brooks Yielding, III, (C), Jefferson Federal Savings & Loan, 213 North 21st Street, 35203, (252-0281).

MID-OHIO HEALTH PLANNING ASSOCIATION, COLUMBUS, OHIO

	Pro- vider	Con- sumer
(5) William E. Brown, M.D. (Franklin), 181 Washington Blvd., Columbus, Ohio Dr. Brown, health commissioner of the city of Columbus, was formerly a member of the Clark County Health Planning Committee.	×	
(6) George W. Byers, Sr. (Franklin), 46 East Town St., Columbus, Ohio Mr. Byers, an automobile dealer and philanthropist, has been a leader in United Appeal and other community activities. For the past few years he served as finance chairman of the Franklin County Health Planning Council, and last year was elected a vice president of the federation.		×
(7) John E. Fisher (Franklin), 246 North High St., Columbus, Ohio Mr. Fisher, president and general manager of Nationwide Insurance Companies, has been a community leader in numerous activities. He served as chairman of the Franklin County Health Manpower Committee and later as chairman of the Areawide Health Manpower Committee.		×
(8) Howard Franz (Franklin), 174 East Long St., Columbus, Ohio Mr. Franz, president of Blue Cross of central Ohio, has long been identified with financing of health care activities. He has also served as campaign chairman of the United Appeal, president of the Franklin County Red Cross, president of Rotary and president of the Navy League.	×	
(9) Paul R. Gingher (Franklin), 311 East Broad St., Columbus, Ohio Mr. Gingher, an attorney, has held most of the community leadership positions in Columbus and has served as international president of the American Automobile Association. For more than 25 years, he has been chairman of the Metropolitan Committee which endorses and promotes delivery in both urban and rural settings. He served on the Scioto County Health Planning Council prior to moving to London.		×
(19) Merle Hartle (Pike), 530 Seal Ave., Piketon, Ohio An engineering official of the Goodyear Atomic Corp., Mr. Hartle is chairman of the Pike County Health Planning Council. Mr. Hartle has a special interest in environmental health problems in the lower Scioto Valley. He is widely known as a leader in Lions Club activities in Ohio.		×
(20) Mrs. Evelyn Hausmann (Licking), 1551 North 21st St., Newark, Ohio Mrs. Hausmann, a housewife, is a member of the Licking County Health Planning Council. She has been active in the Licking County Tuberculosis Association and served as co-chairman of the County Bond Issue Campaign Committee. She is a former member of the Board of Trustees of Licking County Memorial Hospital.		×
(21) Donald R. Haverick (Franklin), 1111 East Broad St., Columbus, Ohio Mr. Haverick, president of Buckeye Union Insurance Company Division of Continental Insurance Co., has been a prominent Catholic layman in many Columbus activities. A former president of St. Ann's Hospital Board, he is a member of the County Hospital Commission.		×
(22) Clark A. Hess, D.D.S. (Ross), 33 West Main St., Chillicothe, Ohio A practicing dentist, Dr. Hess has played a prominent role in the operations of the Ross County Health Planning Council. Dr. Hess has been especially interested in health manpower programs.	×	

	Pro- vider	Con- sumer
(23) Frederick B. Hill (Franklin), 980 Parsons Ave., Columbus, Ohio..... Mr. Hill, Chairman of the Board of the Miraplas Tile Co., has long been an outstanding Meth- odist layman. A former president of Riverside Methodist Hospital, he is currently chairman of The Columbus Foundation, which is a large nonprofit foundation receiving and dispens- ing philanthropy. Mr. Hill has also been prominently identified with the YMCA. A former vice president of the Federation, he is currently chairman of the Franklin County Health Planning Council.		×
(24) William H. Jackson (Fairfield), P.O. Box 415, Lancaster, Ohio..... Mr. Jackson, president of Diamond Power Specialty Co., a division of Babcock & Wilcox, is chairman of the Fairfield County Health Planning Council. He formerly served as chairman of the County Environmental Health Committee in which he has great interest.		×
(25) Rev. Msgr. W. E. Kappes (Licking), 66 Granville Rd., Newark, Ohio..... The pastor of St. Francis DeSales Church, Msgr. Kappes is chairman of the Licking County Health Planning Council. As a member of the Bishop of Columbus' staff, he was promi- nently identified with health and welfare activities in Ohio for many years.		×
(26) Albert H. Kessler (Franklin), 303 East Broad St., Columbus, Ohio..... An official of Columbus Mutual Life Insurance Co., Mr. Kessler has represented the health insurance industry in many activities. As an elected official of the Health Insurance Council and HICHAP, he participated in many conferences and seminars on health care. For the past 2 years he chaired the Federation's committee to develop the Columbus Health Insurance Program (CHIP), a program to provide a prepaid health insurance program for the residents of the Columbus Model Cities area.		×
Lawrence Butler (Morrow), Main St., Fulton, Ohio.....		×
Everett R. Beers (Pickaway), R.D. No. 1, Ashville, Ohio.....		×
Harry T. Vallery (Pike), R.D. No. 2, Lake White, Waverly, Ohio.....		×
James C. Krug (Ross), P.O. Box 523, Bainbridge, Ohio.....		×
Richard Gardner (Scioto), Portsmouth Vetter Ins. Agency, 739 5th St., P.O. Box 1386, Portsmouth, Ohio.....		×
Fred Kreis (Union), 297 North Cherry St., Marysville, Ohio.....		×

FINANCING HEALTH CARE

Albert H. Kessler, Chairman, Columbus Mutual Life Insurance Co., 303 East Broad St., Columbus, Ohio.....		×
H. C. Schuyler (Fairfield), 229 East Allen St., Lancaster, Ohio.....		×
J. Phillip Ambuel, M.D. (Franklin), Medical Director Out-Patient Department, Children's Hospital, 561 South 17th St., Columbus, Ohio.....		×
William C. Ashleman, D.D.S. (Franklin), 327 East State St., Columbus, Ohio.....	×	
Walter T. Bond, M.D. (Franklin), 254 Woodland Ave., Columbus, Ohio.....	×	
W. E. Brown, M.D., M.P.H. (Franklin), Health Commissioner, city of Columbus, Department of Health, 181 Washington Blvd., Columbus, Ohio.....	×	
Robert B. Canary (Franklin), Ohio Department of Public Welfare, 408 East Town St., Columbus, Ohio.....		×
Robert J. DuPont, R.Ph. (Franklin), Academy of Pharmacy of Central Ohio, 2147 North High St., Colum- bus, Ohio.....	×	
William C. Earl, M.D. (Franklin), Children's Hospital, 561 South 17th St., Columbus, Ohio.....	×	
Howard C. Franz, president (Franklin), Blue Cross of Central Ohio, 174 East Long St., Columbus, Ohio.....	×	
Ollie M. Goodloe, M.D. (retired) (Franklin), 2532 Brookwood Place, Columbus, Ohio.....		×
Robert W. Greer (Franklin), 1694 King Ave., Columbus, Ohio.....		×
T. Kline Hamilton (Franklin), 2250 East Broad St., Columbus, Ohio.....		×
George O. Johnson (Franklin), Room 533, School of Allied Medical Professions, 1583 Perry St., Columbus, Ohio.....		×
Robert Murtha, executive director (Franklin), 1st Community Village, 1800 Riverside Dr., Columbus, Ohio.....	×	
Dean Phillips (Franklin), Director of Personnel, North American Rockwell Corp., 4300 East 5th Ave., Columbus, Ohio.....		×
Richard D. Ruppert, M.D. (Franklin), Assistant Dean, College of Medicine, The Ohio State University, 370 West 9th Ave., Columbus, Ohio.....	×	
John W. Schenz, D.O. (Franklin), 2255 West Broad St., Columbus, Ohio.....	×	
Robert Short (Franklin), 1851 Bryden Rd., Columbus, Ohio.....	×	
Richard L. Sims, administrator (Franklin), Doctors Hospital, 1087 Dennison Ave., Columbus, Ohio.....	×	
Braxton E. Tewart, director (Franklin), Division of Community Relations, Ohio State Regional Medical Program, Starling Loving Hall, B-Wing, Room 310, 320 West 10th Ave., Columbus, Ohio.....		×
Richard Lemyre, plant manager (Licking), Kaiser Aluminum Corp., Hebron Rd., Newark, Ohio.....		×
Eugene A. Yazel (Marion), Mayor, city of Marion, City Hall, Marion, Ohio.....		×
Thomas Washam, M.D., LL.D. (Ross), Chillicothe Hospital, 425 Chestnut St., Chillicothe, Ohio.....	×	
Roger A. Burger, vice-president (Scioto), Blue Cross of Southwest Ohio, 1351 Wm. Howard Taft Rd., Cincinnati, Ohio.....	×	

HEALTH MANPOWER

Harry Hamilton, chairman, Director of Editorial Services, Nationwide Insurance Co., 246 North High St., Columbus, Ohio.....		×
Marvin Whitman, O.D. (Franklin), 700 Bryden Rd., Columbus, Ohio.....	×	
(Champaign)		
Robert A. McLemore, M.D. (Clark), 1815 Crescent Dr., Springfield, Ohio.....	×	
(Delaware)		
Walter K. Stewart, administrator (Fairfield), Lancaster-Fairfield Hospital, 401 North Wwing St., Lan- caster, Ohio.....	×	
Marshall Boggs, superintendent (Fayette), Washington C.H. City Schools, 323 East Paint St., Washington C.H., Ohio.....		×
Ollie Goodloe, M.D. (retired) (Franklin), 2532 Bronkwood Rd., Columbus, Ohio.....		×
James R. McCann, M.D. (Knox), Medical Arts Bldg., 812 Coshocton Rd., Mt. Vernon, Ohio.....	×	
George Morrice, Jr., M.D. (Licking), 1689 Bryn Mawr Dr., Newark, Ohio.....	×	
Gerald E. Munn, M.D. (Logan), 120 East Sandusky St., Bellefontaine, Ohio.....	×	
J.J. Hartley, superintendent (Madison), London Public Schools, 60 South Walnut St., London, Ohio.....		×



HIC VIEWPOINT

STATESMANSHIP IN MEDICINE - "THE FOUNDATION FOR HEALTH CARE EVALUATION" The Twin Cities Story

FOUNDATIONS are under consideration by the medical profession in more than twenty-five states. This issue of *HIC Viewpoint* is devoted to one of several variations in the *FOUNDATION* concept, namely the *Foundation for Health Care Evaluation* currently operative in the Twin Cities of Minneapolis-St. Paul. We selected this program because of its unique organization functioning under the leadership of the medical profession taking the initiative in responding to the major areas of public concern with respect to the health care delivery system.

The Twin Cities Story tells why the medical profession in the Minneapolis-St. Paul area embarked upon this ambitious program, delineates the aims of the *FOUNDATION* and provides an overview of how it operates. The *Story* was prepared by the *FOUNDATION* president, Richard E. Anonsen, M.D., Thomas P. Cook, executive secretary of the Hennepin County Medical Society and Carl G. Gustafson, *FOUNDATION* administrative director.

Future issues of *HIC Viewpoint* will be devoted to experimental activities being developed on a similar broad-gauged basis.

Editor

We decided to examine the mounting criticism of the existing health care system with its allegations of physician over-charging; inferior care; inadequate health insurance protection and unjustified escalation in costs due to waste and inefficiency. Inappropriate utilization of ambulatory and institutional services and the lack of or inferior care for rural and inner-city residents have also been scored as has the void existing in health education of the public.

We are keenly aware of such criticism so often headlined in the news media, but physicians have generally been "too busy" to give them the attention they deserve. The result has been a gradual erosion of public confidence in the kind of care being provided even though individuals may be eminently satisfied with the relationships they have with their personal physicians.

Investigation disclosed that such allegations were supported by factual but isolated cases of care which were being inflated to reach sweeping and inadequately supported conclusions of weakness in the system as a whole.

Such criticisms, aggravated by inflation, appeared to be the principal reason for the growing concern for the ability of the average consumer to procure and finance the cost of essential health care. Protagonists were quick to use such criticisms as a public forum

for asserting the need to "revolutionize" the system by abandoning present methods and creating a "new" system patterned after the prepaid group practice model. It is our belief that the complex problems in the present health care system could be corrected without resorting to "major surgery" and only after careful diagnosis revealed the scope of such problem areas.

As long as the individual practitioner oriented his daily life almost exclusively to the care and treatment of patients, such external pressures would eventually bring about drastic changes in the system, influencing the future practice of medicine and the delivery system as a whole, with the experience and professional judgments of the practicing physician exercising little, if any, influence on the end result.

The first step appeared obvious: Develop a new organizational structure, working side by side with the Medical Society with which concerned physicians could readily identify, exerting a leadership role to bring constructive change where needed in the organization, delivery and financing of quality health care.

An attempt was made to identify the problem areas in a reasonable order of priority. The following issues were identified as prime areas of public concern:

1. The need to increase productivity of the provider consistent with a criteria of quality care at reasonable cost;
2. The need to achieve optimum utilization of health facilities and services;
3. The need to improve the availability and accessibility of health care to deprived members of our population;
4. The need to expand existing health insurance benefits to provide a full range of ambulatory, therapeutic, preventative and rehabilitative services; and
5. The need for an intensified program of health education for all customers.

We examined the historical development and operation of some peer review committees which had been in existence for a considerable period of time reviewing and evaluating problem fees generally submitted by third party organizations. The functions of the Peer Review Committee were applied to less than 1% of the total fee problem and in many instances, the consumer was still confronted with the need to finance the difference between the committee's recommendations and the fee originally charged by the physician. A second variation in Peer Review was the medical care foundation concept originally adopted in San Joaquin, California some 17 or 18 years ago. We observed its success in applying the technique of peer review as a means of controlling the reasonableness of physicians' fees, and in exercising some influence in correcting problems of overutilization on the part of patients and, on a more limited basis, unnecessary ambulatory services and treatments rendered by some physicians.

The two fundamental prerequisites of the San Joaquin concept, namely, (1) that insurance programs certified by the Foundation must meet minimum benefit criteria as established by the Foundation, and (2) that the administration of all claims against these certified insurance programs be processed by the Foundation for a specific fee, appeared to limit the scope of the program to serve equally, all residents in the San Joaquin area. Not only did many of the plans installed in the San Joaquin area fail to meet the minimum benefit criteria but the Foundation was competing with the insurance industry in the claims administration function and often at a higher administrative expense to the insured individual. Without debating the merits of the Foundation program, we concluded that it was too limited in scope to enable the medical profession to exercise significant influence on the five major problem areas. We accepted the responsibility of attempting to design a comprehensive program adequate to the needs of our metropolitan area. We knew what we wanted to achieve but were somewhat vague as to how we might attain such goals.

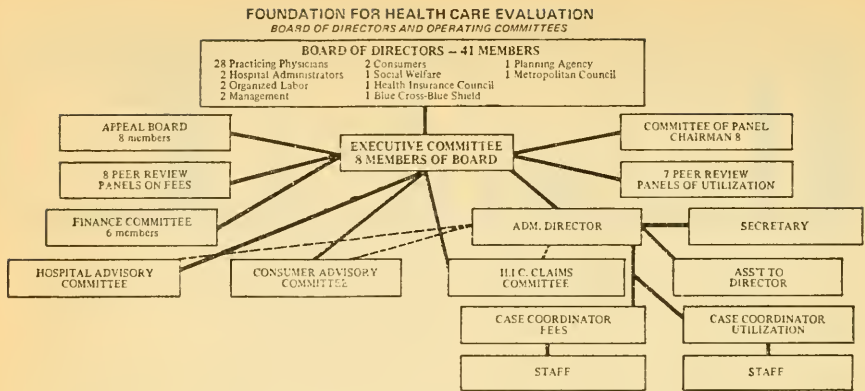
The medical profession's willingness to accept a leadership role in bringing about constructive change

where needed in the health care system made it obvious that the governing body of the Foundation must serve as a forum for public accountability, in judgments made by the practicing physicians in the rendering of care. The influence which hospital administration, comprehensive health planning, management, labor, third-party financing and consumer interests, as well as units of government at all levels, bring to bear on the health care system must be recognized and contended with by the medical profession. The newness of the venture and the need to procure medical support on a voluntary basis from the majority of practicing physicians was a challenge. We recognized the need to utilize the judgment of member-physicians in the correction of problems the Foundation needed to resolve. It was necessary therefore, that the majority of the Board be composed of practicing physicians. However, it was recognized early that the influence of physicians would be readily negated if we talked only to each other and failed to relate to the rest of the health care community. For this reason the composition of the Board with which we started was made up of the following components:

- Twenty-eight practicing physicians
- Two representatives of hospital administration
- One Department of Public Welfare representative
- One representative from the Comprehensive Health Planning Agency and one from the Area-wide Planning Council
- Two representatives from management and two from labor
- Two consumer representatives
- Non-voting representation from third party payers, namely, the Health Insurance Council and the prepaid health service plans, Blue Cross and Blue Shield.

Shortly after the Foundation's launching in May, 1971, the need for direct representation from the consumer in the work of the Foundation as a reflection of the interest and concern of the recipient of such care was forcefully brought to our attention. The Foundation's headquarters was picketed by organized consumers demanding that (1) the prevailing fee guidelines be made public enabling consumers to shop around for the less expensive doctors, and (2) the Board of the Foundation be controlled by consumers. Representatives of the Foundation subsequently held discussions with such consumer organizations and learned that their primary concern was the need for direct input of the consumer's point of view in any impact the Foundation might have in bringing change to the existing system.

Following extended discussions the Foundation Board amended its organizational structure to provide for appropriate consumer representation on this gov-



erning body. A consumer's advisory committee was formed and one of its first and primary objectives was to identify the areas in the Twin Cities Metropolitan community where the health care needs of its residents were not being adequately met. These disclosures proved to be a traumatic experience to many responsible citizens, but served to demonstrate that the future role and accomplishments of the Foundation will be greatly influenced by consumer input. Consumer representation on the Foundation's Board was a critical decision to make but one that we are confident will prove to be the right answer in the future.

Once the Foundation became operative it was evident that a larger and more responsible role must be provided for hospital administrators. Hospital administrative personnel were well qualified to draw on their vast fund of knowledge in this field to evaluate the current problems and provide guidance in developing solutions for them. In due course the Foundation created an advisory committee embracing all hospital administrators in the seven-county Metropolitan area. This committee is the keystone in the development and application of optimum utilization in existing health care facilities and services – and in determining how future facilities, services and manpower needs might be provided on the most economical basis possible.

Once the purpose of our role, and who needed to be involved in the policymaking decisions of the Foundation had been determined, we were then ready to establish a pattern of operation identified with a priority of the Foundation's objectives, namely:

1. A system for monitoring and evaluating physicians' judgments in the delivery of ambulatory and institutional care;

2. A plan for broadening the base of coverage in existing health insurance programs.

3. Identifying areas where health care services are not now available, or are of inferior quality; and

4. Determination of the Foundation's role in consumer health education.

In the monitoring of existing patterns in the health care field, it is necessary to establish norms or screening guidelines based upon a consensus of physicians' judgments – judgments to determine what constitutes an acceptable quality of care under normal circumstances in the treatment of any given diagnosis, and what is considered a fair and reasonable fee for the services rendered.

The guidelines for the ambulatory and institutional services of physicians were developed by panels of practicing physicians usually involved in the treatment of such specific conditions. The guidelines embraced more than 100 diagnoses for ambulatory and a like number for institutional care. Such screens are used to determine when existing practices should be challenged, questioned, or submitted to committees for review and evaluation.

The original guidelines for physicians fees were based upon the combined experience of individual insurance companies and the Blue Shield Plan of Minnesota reflecting the range of prevailing charges made for comparable services by practicing physicians in the Twin Cities Metropolitan area. A display of the fee data reflecting the range of fees within the 50th percentile, 84th percentile, 90th and 100th percentile was then presented. The peer review committees, subject to ratification by the Board, accepted the 84th percentile as the cut-off point with the suggestion that all cases above the 84th percentile be submitted to the Foundation for review and evaluation.

Application of the guidelines as the basis for mon-

itoring the delivery of physician's services was considered to be the responsibility of the participating insurance carriers and prepayment plans with the specific understanding that the cases to be screened for review would be submitted to the following panels:

1. *Fees and Necessity of Ambulatory Care*

A physicians' panel consisting of a cross-section of the medical specialists qualified to evaluate all fees for the necessity of ambulatory treatment of any given disease. In every instance the case is routinely assigned to a physician practicing in the same specialty as the involved physician. The reviewer examines the facts, contacts the attending physician to learn whether additional medical information bearing on the decision should be considered and then prepares a recommendation for submission to the full panel at its next meeting. The panel's final decision is based upon a consensus of the opinion of the whole.

2. *Utilization of Institutional Care*

A panel of physicians drawn from a cross-section of the medical specialties involved includes representation from individuals now serving on the Utilization and Review Committees of hospitals in the Twin City Metropolitan area. The initial evaluation of problem cases is assigned to a physician in the same medical specialty who is not on the same hospital staff as the physician under review.

HEALTH INSURANCE GUIDELINES

While we were quick to acknowledge that the public should have access to a full range of preventive, therapeutic and rehabilitative services, the ability to produce these overnight posed somewhat of a dilemma. Most existing insurance plans fail to provide adequate coverage for preventive care or diagnostic services when rendered on an ambulatory basis. The first question to resolve was whether these plans should be upgraded to comply with our minimum benefit criteria, such as has been historically required in the San Joaquin program, or to establish a blueprint of what constitutes a full range of comprehensive health insurance protection to be used as a guide by the consumer but not required as a prerequisite for participation of the plan in the cost and quality control efforts of the Foundation. The latter course was chosen because if the Foundation's impact on the health care system was to be meaningful it should cut across as broad a segment of the metropolitan community as possible. If cost savings did result because of the Foundation's efforts it was reasonable to assume that employers and the insurance industry might be encouraged to expand the benefits of existing plans, using the savings as generated to underwrite the cost of broader coverage.

ROLE OF THE PRACTICING PHYSICIAN

Every practicing physician in our metropolitan area — whether engaged in solo-practice, single specialty group practice, or multi-specialty group practice, whether paid on a fee-for-service, salary, or capitation basis — has a vital interest in the work of the Foundation and was encouraged to actively participate therein. The Foundation represents the practicing physician in demonstrating his public accountability for his stewardship in providing quality care at a reasonable cost to the consumer. His interest and personal involvement in the discussions of the Board and in the peer review process and evaluation functions of the Foundation is imperative. His commitment in support of the Foundation includes his acceptance of the guidelines and of the judgments rendered by his peers where specific cases may be challenged involving professional care which he has rendered.

We are indeed proud of the way in which the members of the medical profession in the Twin-Cities Metropolitan area have supported their Foundation. At this point 94% of the physicians practicing in this area are Foundation members. All of the medical specialists lent their cooperation and support in the development of the Foundation's screening guidelines, and more than 300 doctors have served on peer review panels without any compensation for the time they have committed to this effort. It is anticipated that during the current calendar year member-physicians will have contributed more than 3600 hours of professional time to the activities of the Foundation. In the spreading of this load, no man will be asked to contribute more than five hours per month.

We view the physicians' response as a vote of confidence in the purposes of the Foundation and an expression of continuing concern for the type and quality of health care dispensed among the residents of this area. This new awareness of the need for the medical community to participate in the decisions which will exercise a significant impact on the practice of medicine bodes well for the future. The problem cases of non-participating physicians will likewise be reviewed and evaluated by the Foundation. When necessary the Foundation will provide an expert witness to support the decision rendered in a given case should litigation subsequently occur between the physician and the patient on the question of the reasonableness of the fee or necessity of the care involved.

ROLE OF THE THIRD PARTIES

The Foundation has sought and obtained the cooperation and support of all existing voluntary health insurance plans including those underwritten by insurance companies and Blue Cross and Blue Shield of Minnesota.

The relationship between the Foundation and any insuring organization is build on the following premises:

1. The practicing physicians will assume responsibility for the screening guidelines, the extent and the scope of the program, and such judgments as might be applied in evaluating the medical care rendered in the community.

2. Participating health care plans and insurance carriers will attempt to stimulate the sale of health insurance benefits meeting the Foundation's guidelines and will apply the Foundation's screening guidelines in their normal claims administration.

The option to request review and evaluation of a disputed case may be initiated by the insurance carrier or prepaid health service plan, the patient or the attending physician. The participating physician, the carriers and the patient, are governed by the conclusions of the reviewing committees.

Such a relationship gives the Foundation the responsibility of exerting the primary influence in the monitoring and the evaluation of physicians' judgments involved in rendering care in the community. We believe this to be one of the most critical points in the entire program and recognizing that the carriers (and others) were reluctant to surrender their prerogatives in claims administration to the Foundation, we had to provide assurances of objectivity and credibility. Two representatives from third parties, one by the Blue Cross-Blue Shield plans and one by the Health Insurance Council, were nominated to provide non-voting consultants on the Foundation's Board and in similar capacity at all Peer Review meetings and appeal Board meetings of the Foundation. This relationship has worked very well in the brief time the program has been operative. It has served to enhance the objectivity of the program and will strengthen our ability to bridge the "credibility gap" which has emerged in many areas between the public and the medical profession.

In addition to the consumer representation we have on this Board, the involvement of representatives of third parties as non-voting Board members and as consultants to review committees, provides the consumer with a sophisticated input into the deliberations and operations of the Foundation that should enhance public acceptance of this program.

The professional time contributed by member-physicians both on the Board and operating committees is not an expense chargeable against the Foundation program. The additional staff and expenses of office overhead to carry out the work of the Foundation is contained in a separate budget charged to the prepaid health service plans and the insurance companies on the basis of the volume of business underwritten by each of them in this particular geographical area.

RELATIONSHIP OF THE FOUNDATION TO THE TWIN CITY METROPOLITAN AREA

The success of the Foundation as a constructive force for future change will, in a large measure, be determined by our effectiveness in functioning as a coalition of community interests in the health care field. There will be coordination between physicians and agencies that include hospital administration, comprehensive health planning agencies, prepayment and insurance plans, management and labor, state and local welfare agencies as well as organizations which are consumer oriented.

The operating responsibility of the Foundation at the present time is focused on the quality and cost issues of monitoring physicians' judgments in the delivery of health services. Wasteful practices in the health care system will be identified and discouraged by application of the principle of "peer evaluation." Recommendations for corrective action will exert a significant impact on the total delivery system only when all other components of the health care community are working harmoniously with us in support of public interest.

The appointment of a consumer's advisory committee to the Board, in addition to representation from management and labor, expanded the Foundation's exposure to a wide range of consumer interests and enabled it to get closer to the concerns of the beneficiaries of our health care system. Consumer activity will prove to be a vital part of our total program — providing guidance on the unmet health needs of concern to the community and on subsequent proposals which will bring about change in our health care system.

The Foundation needs to provide a new blueprint for cooperative action, eliminating the adversary relationship which has often vitiated the capacity of the voluntary sector to work in partnership with each other and with government.

Pressure to "revolutionize" the health care delivery system continues to increase. Proponents of this philosophy demand that the consumer be given a choice in the way his health is financed and delivered. A further stipulation is that physicians identify with a new model under which he either works on a salary basis or agrees to provide specific amounts of service for a predetermined amount of money (capitation payments). The Foundation has not taken a position on this issue, recognizing that each physician has the option to determine under which type of delivery system he wishes to practice and what method of reimbursement he will accept for his services.

We believe, however, that this issue involves several principles with which we can identify:

1. The right of the consumer to obtain health care from competing delivery systems, (e.g., solo practice; single-specialty group practice; and multi-specialty group practice.)

2. The right of the individual physician to work under any of the various options and be paid on a salary, capitation, or fee-for-service arrangement.

3. The right of the individual patient to choose or change physicians depending upon his degree of satisfaction with the care received.

Each of the existing models for delivery and financing health care have strengths and weaknesses of their own. The fee-for-service, solo practice, single-specialty group practice, and multi-specialty group practice approach are vulnerable both to overcharging and over-utilization of services since it is obvious that the physician's income increases in proportion to the volume of service delivered and the fees charged. However, one of the plus factors in this arrangement is the built-in incentive to increase productivity by taking care of more sick patients, thereby, increasing both his production and income.

Conversely, the salary or capitation arrangement eliminates economic barriers for the patients' demand for care and requires that the physician spend some of his time with the "worried well." There may be times when the consumer will elect to change physicians and obtain care outside the capitation plan, thus increasing his total cost. Finally, there is the question whether in the absence of a fee-for-service incentive, the physician will increase his productivity in taking care of more people and provide an adequate level of care when his time has been paid for in advance?

The Foundation's primary role in this area should be to provide a vehicle for evaluating the cost, quality, and productivity of competing delivery systems designed to serve the health care needs of the consumer. The Foundation's guidelines, its peer review and evaluation process, the monitoring of the process by representatives of the third parties, and the broad scope of Board representation, offer a unique system for discharging these responsibilities on a credible basis. In effect we have said that we are best qualified to evaluate the performance of the medical profession in a way that will enable the public to make an informed choice when deciding where and how to obtain care and on what basis to pay for it.

Our "Health Insurance Guidelines" represent a comprehensive range of coverage which can be offered the consumer through several options:

(a) by a capitation arrangement;

(b) by expanding existing insurance protection to pay for the cost of ambulatory care and preventative health services; or

(c) by assuming the additional cost directly from current income.

The consumer is entitled, however, to the assur-

ance that whatever option is used, the care rendered meets the medical profession's criteria of quality and reasonableness of cost.

PERFORMANCE TO DATE

Our Foundation is less than one year old. However, we can already look to accomplishments in specific areas and we are developing tentative plans for future expansion which will broaden and strengthen its effectiveness.

First, let's look at the accomplishments:

(a) *Geographical expansion of the Program.*

Initially limited to the Greater Minneapolis area, the program now embraces the seven counties of the Minneapolis-St. Paul Metropolitan area, with more than 2100 doctors of medicine, 28 hospitals and in excess of two million residents.

(b) *Carrier Participation.*

Virtually all of the major insurance carriers in the area (34 in all) and Minnesota Blue Cross-Blue Shield participated in the program during its initial year of active operation.

(c) *Experience with Physicians Fees.*

Of the total number of cases reviewed to date, it is apparent that less than 1% of all claims involving physicians' charges have exceeded the guideline limits. Of the 579 cases involving fee evaluation, 57.4% were reduced and 42.6% were approved as submitted.

Surveys of physicians charge data for specific diagnoses were conducted at the year-end interval to determine the general rate of escalation of physicians fees in this area, with physicians generally determining their own fee levels. The survey disclosed an increase of slightly less than 2% at the 50th percentile figure and at the 84th percentile the increase was lower than at the 50th percentile.

We believe this experience is significant in two respects: First, there were relatively few instances in which the physicians charging practices in our community exceeded the prevailing fee guideline and were challenged by third-party insurers; second, and most important from the standpoint of the consumer in our community, is the fact that the general rate of escalation in physicians' fees was 50% below the national average, resulting in substantial savings to the public. The cumulative effect of this trend extended over the next several years will obviously generate savings in the millions.

The fee guidelines were initially limited to the 32 most frequent procedures. They have now been expanded to include an additional 47 procedures and guidelines for the specialties of anesthesiology, radiology and pathology.

(d) *Experience with Utilization.*

1. *Ambulatory Physicians Services* — In developing guidelines for screening the necessity of physicians services, including a quality component, it was intended that the carriers would utilize this information as a screen in normal claims administration. The Foundation's first year of experience made it abundantly clear that the information required to perform this task is not normally available on routine claim forms, thus limiting the carriers ability to apply this type of guidelines. At this point in time we do not have a reliable measurement of the problems existing in this area. In cooperation with our physicians we are examining the degree of interest on a pilot basis in the application of a standard patient treatment form to be used as the basic input for a computerized screening process in this area.

2. *Institutional Services* — The original thought here was that the guidelines for the more than 100 diagnoses which relate to most of the reasons for hospital confinement would reflect medical indications for the justification for the admission, the type and extent of the services rendered, and the appropriateness of the duration. Such guidelines were put together based upon the consensus of the judgments of the various specialties involved as to what constitutes quality of care in the treatment of a given disease.

Two problems were encountered. First, there was the fact that the duration guidelines were drawn on too liberal a basis resulting in too few cases being submitted for evaluation. Second, the carriers were again unable to apply a quality screen based upon information ordinarily contained on routine claim forms. The initial plan was that this type of review would be conducted on a retrospective basis following the patient's discharge from the hospital and after the claim was paid for the confinement involved, with corrective action to be applied prospectively where deemed necessary.

To strengthen performance in this phase of the utilization review program, plans are being implemented to apply current control on hospital stays which exceed the 75th percentile of the duration data compiled by PAS and applicable to our region. The intention is to influence practices to accommodate to an earlier discharge date when deemed medically advisable, thereby reducing unnecessary confinements and eliminating the hospital collection problem which occurs in those instances where the third party reduces the amount of its payment following the departure of the patient from the hospital.

We are exploring the possibility of a computerized screening system to obtain a more reliable measurement of the quality of the care rendered and a more effective method for isolating cases which require evaluation. The future thrust of our Foundation program will be to lean heavily on changing the patterns of physicians practices where necessary through the effective monitoring of hospital stays and meaningful education of those physicians rendering inferior care.

FUTURE ROLE OF THE FOUNDATION

Almost the entire first year has been spent on the problems of cost and quality in our health care system and the development of a plan for eliminating unjustified costs and encouraging optimum utilization of existing facilities and services. During the coming year we intend to focus on the major problems of availability and accessibility of care for the total population in this seven-county Metropolitan area, seven days a week, twenty-four hours a day, expansion of prevailing health insurance benefits, and the development of a consumer health education program.

The time has come to explore with other professionals in the health care delivery system, namely, the dentists, pharmacists, nursing home administrators, home care agencies, etc., where it is feasible and practical for them to link up with the Foundation and develop their own peer evaluation processes for monitoring the services of their members and join with the rest of the community through representation on the Foundation's Board in discussions of the larger problems which effect the entire health care system.

It is readily acknowledged that we are one of the youngest foundation programs in operation at this time. There is no one perfect solution to the way in which each community, both metropolitan and rural, discharges its responsibilities in the health care field. We have learned a great deal in the first full year of active operation, have tried to be open-minded and flexible in discarding ideas that do not work, and eager to try new ones which appear to hold forth greater promise. A significant change has occurred within the ranks of our member-physicians. They have developed a strong esprit de corps, and stand ready and willing to face the challenge of change, capable of responding to the charges of their critics and exercising a sense of leadership that reflects the dedication of the practicing physicians to discharge their responsibilities to the people in this seven-county Twin Cities Metropolitan area.

Copies of this pamphlet may be obtained for distribution to interested groups from the HEALTH INSURANCE COUNCIL, 750 Third Avenue, New York, N.Y. 10017.

Senator HART. Any further questions?

Gentlemen, thank you very much.

Mr. HEMRY. Thank you.

Senator HART. We will adjourn, subject to the call of the chair.

(Whereupon, at 3:29 p.m., the subcommittee adjourned, subject to the call of the Chair.)

COMPREHENSIVE HEALTH PLANNING ASSOCIATION OF THE GREATER OTTAWA
VALLEY, LIMA, OHIO

PROGRESS REPORT

Our problems regarding local funding have been resolved as a result of the following:

1. As a member of the United Fund our Association will receive at least \$10,000 or more per year.

2. A resolution was passed at the January 20th meeting of the Western Ohio Hospital Council stating that member hospitals will provide \$14.00 per bed for the fiscal period June 1, 1971 thru May 31, 1972 and \$7.00 per bed for the fiscal period June 1, 1972 thru May 31, 1973.

3. Acceptance by the county for funding responsibility will guarantee total funding.

LIST OF BOARD MEMBERS

Name and address	Consumer or provider	Primary occupation	Affiliations	Reason for selection	Term of office expires
ALLEN COUNTY					
John E. Paplow, 411 Crayton.....	P	Hospital Administrator, Lima Memorial Hosp.	Fellow-American College of Hospital Admin., AHA, OHA, American Red Cross-Allen Co. Board, West Ohio Hosp. Council, Ohio State RMP, NW Ohio RMP Exec. Board, Adv. Board Ohio State Board of Nursing Admin. and Nurse Reg. Exec. Com. Hospital Serv.	Hospital Administrator.....	1972
Mrs. Joan Cooper, 12 N. Broadway, Spencerville, Ohio.	P	Dietician, R.D.	American Dietetic Assoc., Lima-Allen Co. Nutrition Council, Ottawa Valley Continuing Educ. Council, Community Nutrition Sec.-Toledo Dist. Dietetic Association	Woman and Nutritionist.....	1974
Lary Fowler, D.D.S., 39 West Market, Lima, Ohio...	P	Orthodontist	Lima Academy of Dentistry Northwestern Ohio Dental Society, Ohio Dental Assoc., American Assoc. of Orthodontists, Great Lakes Society of Orthodontists.	Practicing Dentist.....	1972
Chester L. Bernstein, O.D., 138 High Street, Lima, Ohio 43801.	P	Optometrist	American Optometric Society	Optometry Representative.....	1972
R. Vaughn Rinard, 336 Ervin Rd., Van Wert, Ohio...	C	Insurance Central Mutual Ins. Co.	President of Van Wert County United Health Foundation, Inc., very active in community.	Insurance and Community Affairs.....	1974
Mrs. Mary Hetrick, 1015 Ervin Rd., Van Wert, Ohio...	C	Teacher	American Association of University Women	Teacher.....	1972
PROVIDERS-AT-LARGE					
Robert G. West, 1034 Rosemont Dr., Van Wert, Ohio.	P	Hospital Adminis., Van Wert County Hospital	AHA, OHA, West Ohio Hospital Council	West Ohio Hospital Council Rep.....	1972
Frederick Eckfeld, 420 N. Detroit St., Kenton, Ohio.	P	Hospital Adminis., Hardin Memorial Hospital.	do	do	1972
James T. Haidle, D.D.C., 300 Metropolitan, Lima, Ohio.	P	Podiatrist	NW Academy of Ohio Podiatry Association	Podiatry Representative.....	1972

Robert S. Oyer, MD, 815 W. Benton, Wapakoneta, Ohio.	P	Health Commissioner	AMA, Ohio State Med. Assoc., APHA, Ohio State Health Commissioners.	Health Com. Representative	1972
To be selected before Mar. 6, 1972.	P	Pharmacist		Pharmacist's Rep	1972
Maria G. Solis, Bo 199, Leipsic, Ohio	C	Outreach Worker for CAC in Putnam and Hancock Counties.	Alter Rosary, Guadalupe Society, Christian Movement.	Migrant Worker Rep.	1974
Mrs. Janice Niese Route #1, Leipsic, Ohio.	C	Cosmetic Distributor	CAC Committee, Adv. Bd. of Neighborhood Opportunity Center.	Woman and Minority Rep.	1974
Mrs. Howard Weller RR #2, Continental, Ohio 45831.	C	Farming	Chairlady of the Farm Bureau's Women's Com.	Farming and Agriculture Rep.	1972
VAN WERT COUNTY					
Robert Saunier, DDS, 4 Willow Laye, Van Wert, Ohio.	P	Dentist	NW Ohio Dental Soc., Chamber of Commerce Community Development.	Dentistry	1973
Donald Hughes, M. D., 8 Warren Rd., Van Wert, Ohio.	P	Pathologist	Van Wert Co. Medical Society, Van Wert Area Chamber of Commerce.	Pathologist	1973
T. A. Gessler, Route #2, Convoy, Ohio	C	Co. Commissioner	Chamber of Commerce- YMCA, Van Wert Co. Assoc. for Mentally Retarded, Camp Fire Girls, St. Pauls United Church of Christ, Co. Commissioners Assoc. of Ohio, Clerks and Trustees Assoc. of Van Wert Co.	Association President County Government	1974
Richard Langenkamp, Box 116, St. Henry Ohio.	C	N.F.O. Livestock Collection Point Representative.	NFO, K of C	Rep. Farm and Agriculture Groups	1973
Lee Cass, RR #4, Celina, Ohio	C	Social Work	Auglaize-Mercer Community Action Com.	Social Worker and Minority Rep	1974
PAULDING COUNTY					
Oliver E. Stemen, Box 173, Grover Hill, Ohio	P	Sanitarian	Paulding Co. Health Department	Sanitarian Public Hlth. Rep	1974
Laura Zepernick, 405-B Hopkins, Paulding, Ohio.	C	County Ext. Agent	Cooperative Extension Service	County Government	1972
Mrs. Ilo Weibel, 345 S. Williams, Paulding, Ohio	C	Housewife (former teacher)		Education	1973
PUTNAM COUNTY					
Ray Meyer, Route 3, Columbus Grove, C. 45830	P	Sanitarian	Putnam County Health Department	Sanitarian	1973
Joseph McHugh, MD, 705 East Main, Ottawa, Ohio.	P	Physician	Health Commissioner Board TB and Resp. Dist. Board-Cancer Society.	Health Commissioner	1973

LIST OF BOARD MEMBERS—Continued

Name and address	Consumer or provider	Primary occupation	Affiliations	Reason for selection	Term of office expires
MERCER COUNTY					
Mrs. Frances Shields, 301 South Patterson, Forest, Ohio 45843.	C	Co-owner of funeral home	Representing Hardin Co. Commissioners, organizer, Forest United Methodist Church, Pres. Lima Dist. Women's Soc. of Christian Service, W. Ohio Conf. Women's Soc., Forest Mother's Study Club, Senate Chap. of Order of Eastern Star, Rebeccas.	Represents Hardin Co. Commissioners	1973
Robert Bischoff, Ada, Ohio 45810	C	Mayor of Ada Businessman	City and Village Mayors and Township Trustees organization, County Health Advisory Council.	City Government	1972
MERCER COUNTY					
Charles H. Dickman, OD, 616 Plum Dr., Coldwater, Ohio.	P	Optometrist	BPOE, Lions, Amer. Optometric Assoc., also state and area groups, Chrmn Mercer County CHP Council.	Practicing Optometrist	1972
R. L. Dobbins, M.D., 5348 State Rt. 29 E, Celina, Ohio 45822.	P	Physician	Mercer Co. Medical Soc., AMA, KolC, American Assoc. of Family Practitioners.	Physician	1973
Thomas Rable, 622 N. Walnut, Celina, Ohio	C	Personnel Manager Reynolds and Asst. VP 1st National Bank of Findlay	KolC, Personnel Assoc. of NW Ohio, Wright State Com. on Associate Degree Programs.	Industry	1974
Wayne L. Pebble, RR 3, Arlington, Ohio	C	Planner-Hancock Regional Planning	Treas. Hancock Regional Planning, United Fund Co. Captain, Chamber of Commerce Education Com., American Red Cross 1st Aid Instruct, Boy Scouts Chamber of Commerce, Historical Society.	Business	1974
Larry Musser, 514 Allen, Findlay, Ohio	C			Regional Planning	1973
HARDIN COUNTY					
W. M. Finerty, DSC, 715 Gilmore St., Kenton, Ohio 43326.	P	Podiatrist	Chrmn, Hardin Co. CHP Council; Ohio Podiatry Assoc. CHP Committee State Chrmn; NW Ohio RMP Adv. Group; 648 Board, Chrmn of Immaculate Conception Parish Finance Com.	Practicing Podiatrist	1974
Thomas Palston, 616 N. Cherry, Kenton, Ohio 43326.	P	Pharmacist	Hardin Memorial Hosp and Hardin County Home, Chrmn Crippled Childrens Assoc., Kenton City Council, Hardin Co. March of Dimes.	Practicing Pharmacist	1973
Russell Southward, RR 1, Kenton, Ohio 43326	C	VP Manufacturing International Car	Elks, Patterons Methodist Church, Kenton Co. CHP Council.	Industry	1974
Donald Harden, 333 N. Walnut, St. Marys, Ohio	C	Bank President 1st National Bank of Wapakoneta St. Marys Branch.	V.F.W., Eagles, Masons, Rotary	Business	1973
Kenneth Hagemann, St. Marys, Ohio	C	Service Director City of St. Marys	Rotary, Regional Planning	Regional Planning	1973

HANCOCK COUNTY

William Ruse, 145 W. Wallace, Findlay, Ohio.....	P	Hospital Admin. Blanchard Valley.....	AHA, OHA, West Ohio Hospital Council.....	Hospital Administrator.....	1973
John Smithson, M.D., 921 S. Main, Findlay, Ohio.....	P	Physician (Internist).....	Hancock Co. Medical Society.....	Practicing Physician.....	1974
Miles Kardatske, OD, 700 N. Cory, Findlay, Ohio.....	P	Optometrist.....	Ohio Optometric Society.....	Optometry.....	1972
James Parriott, 1902 Queenwood, Findlay, Ohio.....	C	Dir. of Public Affairs Marathon Oil.....	American Bar Assoc., Chamber of Commerce, Boy Scouts, Chrm. Hancock Health Planning Council.....	Attorney.....	1972
Ray Saldana, 1636 Payne Ave., Findlay, Ohio.....	C	Neighborhood Opportunity Center Director for C.A.C.....		Minority.....	1974
Mrs. Barbara Pirtle, 133 South Jackson, Lima, Ohio 45801.....	C	Housewife.....		Minority Group Woman.....	1972
Mrs. Zena Beers, 1655 Sunrise Dr., Lima, Ohio 45805.....	C	Housewife.....	Head Start Adv. Bd. Adv. Council-Allen Co. Ext. active club woman.....	League of Women Voters Representative.....	1973
Henry Hollinger, 218 West Market, Lima, O. 45801.....	C	Civil Engineer, Kohli & Kalther.....	Kiwanis Club, Mizpah Community Center Board, Trustee-Trinity United Methodist Church, Lima Society of Professional Engineers, American Society of Civil Engineers.....	Environment interest.....	1974
Mrs. E. D. Broyles, 414 South Nye, Lima, Ohio.....	C	Secretary, Procter & Gamble.....		Woman Minority Group.....	1973

AUGLAIZE COUNTY

Bruce Bubb, 236 South Main, St. Marys, Ohio 45885.....	P	Industry Rep., Goodyear Tire Health Program.....	Rotary Club.....	Industry Rep.....	1974
Robert Harman, 420½ W. Spring, St. Marys, Ohio 45885.....	P	Administrator, Jt. Township Hosp.....	Rotary, Ottawa Valley Planning Council.....	Hospital Administrator.....	1974
Terry Dick, 408 E. Front, St. Marys, Ohio 45895.....	C	Insurance Salesman.....	Allen Co. Council of Alcoholism, Allen Co. Diabetes League, Ohio Conf. of TB & Respiratory Disease Workers, Subregion No. 2 Continuing Education Planning Com., Ohio Public Health Assoc., National Respiratory Disease Conf.....	Insurance Woman.....	1972
Mrs. Kaye McClair, Box 870, Lima, Ohio.....	P	Executive Director, Allen Co., TB & Health.....		Voluntary Organization.....	1973
David A. Barr, M.D., 825 West Market, Lima, Ohio.....	P	Physician.....	President of Allen Co. Academy of Medicine.....	Practicing Physician.....	1972
Thomas Dube, 730 West Market, Lima, Ohio 45801.....	P	Assist. Admin., Professional Serv., St. Rita's Hospital.....	AHA, OHA, Kiwanis, Board Member of Allen Co. Heart Assoc., etc.....	Health Administrator.....	1973
Christian P. Morris, 219 E. Market, Lima, Ohio.....	C	Mayor.....		Mayor City of Lima.....	1972
Richard Thompson, Defiance Trail, Delphos, Ohio 45833.....	C	County Commissioner.....	President—Ohio State Association of County Commissioners.....	County Government.....	1972
Sam Bassitt, 1120 Fett, Lima, Ohio.....	C	Associate Director, Allen County Technical College.....		Education.....	1974

*Areawide Comprehensive Health Planning in the Central Ohio River Valley
(Ohio, Indiana, and Kentucky)*

Assurance of local matching financial support

Blue Cross of Southwest Ohio.....	\$16, 680
Blue Cross of Kentucky.....	1, 500
Greater Cincinnati Hospital Council (contributions from hospitals, at \$4.50 per bed).....	25, 000
Hamilton County.....	10, 000
The Community Chest and Council of the Cincinnati Area.....	30, 400
Model city contract (pending 2d year funding).....	40, 055
Total.....	123, 635

Note: Verbal and/or written assurance has been received from the above sources regarding financial support, in the amounts indicated for CORVA's fiscal year, June 1, 1972, to May 31, 1973.

Walter Blair (Consumer, 1-year term), Room 301, Municipal Building (Office), Hamilton, Ohio 45011; 270 S. Washington Blvd. (Home), Hamilton, Ohio 45013.

Mr. Blair is the present Planning Director of the City of Hamilton. He is also the Secretary of the Executive Committee of CORVA and a member of Areawide Environmental Health Committee. Mr. Blair is a past Chairman of the Budget Committee of United Community Services, and was a two-year member of both the Planning Committee and the Agency Evaluation Committee. He also is a member of the Board of Directors of OKI and serves on the Executive Committee.

John M. Bullock (Consumer, 2-year term), First National Bank (Office), P.O. Box 1033, 111 E. 4th Street, Cincinnati, Ohio 45202; 6749 Wetheridge Drive (Home), Cincinnati, Ohio 45230.

Mr. Bullock is the President-elect of the Board of Trustees for CORVA. His occupation is Senior Vice President for First National Bank. Mr. Bullock is presently on the Board of Trustees of CORVA, Providence Hospital, St. Francis Hospital, St. Mary's Hospital, Cincinnati Symphony Orchestra, Children's Hospital, as well as Secretary of the Gale Charitable Foundation. He was also Past Chairman of the Hamilton County Mental Health and Mental Retardation Board.

Past health related activities include membership on the Board of Trustees of the Central Psychiatric Clinic, Child Guidance Home, Hamilton County Association for Slow Learners, Hamilton County Diagnostic Clinic for Mentally Retarded, Health Careers Association of Greater Cincinnati, and United Services for the Handicapped. Mr. Bullock was also on the Cincinnati Board of Health, Mental Health Advisory Committee.

R. Arthur Carvolth (Provider, 2-year term), St. Luke Hospital (Office), 85 N. Grant Avenue, Ft. Thomas, Kentucky 41076; 72 Highview (Home), Ft. Thomas, Kentucky.

Mr. Carvolth is the present Administrator of St. Luke Hospital. He has been affiliated with the Northern Kentucky Health and Welfare Council, and the Kentucky Hospital Association, as well as the Greater Cincinnati Hospital Council. He is a member of CORVA's Areawide Manpower Committee.

Homer W. Connor (Provider, 3-year term), Dearborn County Hospital (Office), 600 Wilson Creek Road, Lawrenceburg, Indiana 47025; Outer Drive (Home), Aurora, Indiana 47001.

Mr. Connor is the present administrator of Dearborn County Hospital. His interest in community affairs includes membership on CORVA's Areawide Health Facilities Committee. He is a member of the Executive Committee of the Lochry Valley Health Planning Association.

Ruth Dalrymple, R.N. (Provider, 2-year term), College of Nursing & Health (Office), St. Clair & Vine Streets, Cincinnati, Ohio; 5720 Winton Road, Apt. 514 C (Home), Cincinnati, Ohio 45232.

Miss Dalrymple is the Dean of the Nursing College at the University of Cincinnati. She is a member of the Health Council of the Community Chest and a member of CORVA's Areawide Manpower Committee. She is also a member of District 8 Committee on Nursing Education.

William R. Elsea, M.D. (Provider, 3-year term), 3101 Burnet Avenue (Office), Cincinnati, Ohio 45229; 723 Clinton Springs Avenue (Home), Cincinnati, Ohio 45229.

Dr. Elsea is Commissioner of Health for the City of Cincinnati. He is affiliated with the Ohio and American Public Health Associations.

Dr. Elsea is also on the Board of Trustees of the Hamilton County Health Planning Association.

Gerald Ewbank (Consumer—Ex-Officio with vote), 114 W. High Street (Office), 34 Laurel Avenue (Home), Lawrenceburg, Indiana 47025. Mr. Ewbank has been the attorney for the Dearborn County Hospital for the past 17 years. He also is Chairman of the Lochry Valley Health Planning Association. Mr. Ewbank is a member of the American Society of Hospital Attorney's. He is past vice), 34 Laurel Avenue (Home), Lawrenceburg, Indiana 47025. Mr. Ewbank is a member of the American Bar Association and on the Board of Managers of the Indiana State Bar Association.

Hon. Ambrose Fields (Consumer—1-year term), Pendleton County Fiscal Court (Office), Falmouth, Kentucky. Mr. Fields is the fiscal court Judge for Pendleton County, Kentucky.

Robert A. Gellenbeck (Consumer—1-year term). Gellenbeck Insurance Co. (Office), 2330 Victory Parkway, Cincinnati, Ohio 45206, 981 Timber Trail (Home), Cincinnati, Ohio 45224. Mr. Gellenbeck is the President of Gellenbeck Insurance Agency. He is a twelve-year member and current President of the Hamilton County Unit of the American Cancer Society, and a twenty-year member of the Lioba Society of St. Mary's Hospital.

Leo Glass (Provider—2-year term), 8503 Miami Avenue (Home), Cincinnati, Ohio 45236. Mr. Glass is Vice President of Glass Nursing Homes, Inc., and is a member of CORVA's Area-wide Community Health Services Committee.

Lloyd Goggin (Consumer—2 year term), Miami University (Office), Oxford, Ohio 45056, 495 Shadowy Hills (Home), Oxford, Ohio 45056. Mr. Goggin is the Vice President for Finance and Business Affairs and Treasurer at Miami University. He is also a Trustee of the Miami University Foundation and Treasurer of Miami University Pulp and Paper Foundation. He is on the Board of Trustees of McCullough-Hyde Memorial Hospital and Butler-Warren Health Planning Association. In addition, Mr. Goggin is President of the Oxford United Appeal and a member of the Board of Trustees of the Citizen's Bank in Hamilton, Ohio.

Robert F. Greene (Consumer—3 year term), No. 3 Washington Avenue (Office), Burlington, Kentucky 41005, 827 Linaburg Road (Home), Hebron, Kentucky 41048. Mr. Greene is a practicing Attorney in Boone County. He is currently a member and past President of the Northern Kentucky Community Action Commission Board of Directors. He is also a Board member of the Family Service of Greater Cincinnati. Mr. Greene is active in the Boy Scouts and the U.S. Army Reserves, with the rank of Colonel. Past activities in Boone County include Juvenile Judge, Counsel of the County Water Commission, and the Jaycees. He is a member of the Boone County, Kanton County, Kentucky State and American Bar Associations, as well as the American Trial Lawyers Association.

Donald P. Hammer (Consumer—2 year term), Joseph E. Seagrams & Sons, Inc. (Office), Main & Mill Street, Lawrenceburg, Indiana 47025, 3 Circle Drive (Home), Lawrenceburg, Indiana 47025. Mr. Hammer is the Plant Manager at Seagrams & Sons, Inc. He is also a member of the Lochry Valley Health Planning Association. Mr. Hammer is the Director and Budget Chairman for the Dearborn County United Fund.

David J. Hegggen (Consumer—1-year term), Union Central Life Insurance Co. (Office), P.O. Box 179, Cincinnati, Ohio 45201, 619 Vincennes Court (Home), Cincinnati, Ohio 45231. Mr. Hegggen is Second Vice President of Union Central Life Insurance Company. He is a member of the University of Cincinnati Project Board; Ambulatory & Emergency Room Grant, and a member of the Emergency Room Ad Hoc Committee of the Greater Cincinnati Hospital Council. Mr. Hegggen is a member and Past Chairman of the Ohio State Health Insurance Council, the Southwestern Ohio Health Insurance Council and the Cincinnati Life Accident & Health Claim Association.

Stephen P. Hogg, M.D. (Provider—3 year term), 250 Wm. Howard Taft Road (Office), Cincinnati, Ohio 45219, 3327 Stettinius Avenue (Home), Cincinnati, Ohio 45208. Dr. Hogg is a physician in private practice. He is a member of the Rotary Club. He is the immediate past President of the Cincinnati Academy of Medicine and past President of both the Cincinnati and Ohio State Otolaryngology Societies. Dr. Hogg is currently President of the Mid-West Foundation for

Medical Care and Vice-President of the Regional Association of County Medical Societies. In addition to being on CORVA's Board of Trustees, he is a member of the Areawide Community Health Services Committee.

Pearl Houston (Consumer—1 year term), 1318 Wheeler Street (Home), Covington, Kentucky. Mrs. Houston is a Consumer Representative to the Board of Trustees. She is also active in the continuing development of the Covington, Kentucky, Model Cities Program and is a past Board member.

Robert J. Hunter (Consumer—1 year term), R.R. 2, Corinth, Kentucky. Mr. Hunter is a Magistrate in Corinth, Kentucky.

Henry Jones (Consumer—1 year term), 1525 Linn Street (Office), Cincinnati, Ohio 45202, 3972 Abington Ave. (Home). Cincinnati, Ohio 45229. Mr. Jones is Associate Director of the Cincinnati Community Action Commission. He also serves as a Board member for Careers in Social Work and Central Community Health Board.

Thomas J. Klinedinst (Consumer—1 year term), Thomas E. Wood Insurance Co. (Office), Carew Tower, 28th Floor, Cincinnati, Ohio 45202, 2531 Observatory (Home), Cincinnati, Ohio 45208. Mr. Klinedinst is Past President of CORVA and on the Board of Trustees of two area hospitals: Providence and St. Francis. His community activities also include trusteeship of the Cincinnati Symphony Orchestra and trustee of the Hillsdale Lottspeich School.

Paul H. Klingenberg, M.D. (Provider—2 year term), 607 Coppin Building (Office), Covington, Kentucky 41011. Dr. Klingenberg is a practicing surgeon with interests in the Community Action Commission, Medical Society, and Northern Kentucky Mental Health Board. He is also a member of CORVA's Areawide Community Health Services Committee.

J. W. Krausser (Consumer—1 year term), P.O. Box 191 (Home), Felicity, Ohio 45120. Mr. Krausser is retired as Chief of Engineering of the Procter and Gamble Co. He is past President of the Cincinnati Air Pollution Control Board and a member of the Board at the Cincinnati Zoo.

Edward W. Lange (Consumer—Ex-Officio with vote), 2703 Mario Way (Home), Ft. Mitchell, Kentucky 41017. Mr. Lange has been associated with mental health, child welfare, T.B. studies, hospital studies, Red Cross and other health-related organizations in the Northern Kentucky area. He is currently the President of the Northern Kentucky Health and Welfare Planning Council.

Joseph Lindner, Jr., M.D. (Provider—3 year term), College of Medicine (Office), General Hospital, Cincinnati, Ohio 45219, 3461 Manor Hill Drive (Home), Cincinnati, Ohio 45219. Dr. Lindner is Assistant Dean of the College of Medicine, University of Cincinnati. He is also a member of CORVA's Areawide Community Health Services Committee, a Board member of Project Hope and a member of Children's Protective Association.

Rev. Paul Livesay (Consumer—3 year term), 310 5th Avenue (Office), Carrollton, Kentucky 41008, 407 Seminary Street (Home). Reverend Livesay serves on the state committee on licensing and ordinances for ministers, and the state committee on Ministry for churches within Kentucky, the Christian Church of the Disciples. He also serves on the local board of the Red Cross, Mental Health and Mental Retardation in Region #7, and the Board of Trustees of the Northern Kentucky Health & Welfare Planning Council, a subregional unit of CORVA. Reverend Livesay was graduated from the University of Lexington and the Lexington Theological Seminary.

Calvin F. Lloyd (Consumer—3 year term), Executive Savings & Loan Association (Office), Middletown, Ohio 45042, 3305 Poinciana Road (Home), Middletown, Ohio 45042. Mr. Lloyd is President of the Middletown Civic Association, and member of the Board of Trustees, Middletown Hospital. He is also a member of the Rotary Club.

Donald I. Lowry (Consumer—2 year term), Procter & Gamble Company (Office), Industrial Chemical Division, Cincinnati, Ohio 45217, 6700 Given Road (Home), Cincinnati, Ohio 45243. Mr. Lowry is President of CORVA's Board of Trustees. He is a Manager of the Industrial Chemical Division at the Procter & Gamble Company in Cincinnati. Mr. Lowry is past President of the Greater Cincinnati Hospital Council, Chairman of the Administrative Committee at Bethesda Hospital, a member of the Hamilton County Hospital Commission, Chairman of the Regional Advisory Council, and the Ohio Valley Regional Medical Program. In addition, he is past President of the Board of Trustees of the Cincinnati Country Day School and President of the Southwest Ohio Water Company.

Nancy M. Mauricio (Provider—3 year term), 412 S. High Street, Rising Sun, Indiana 47040. Mrs. Mauricio is a Registered Nurse on the staff at St. Francis

Hospital. She is on the Board of Directors for the Community Mental Health Out-Patient Clinic, Inc. She is also active in the Ohio County Historical Society and a member of the Ohio County Council.

Walter A. Mischley (Provider—1 year term), Middletown Hospital (Office), Middletown, Ohio. Mr. Mischley is the Executive Vice President of Middletown Hospital. He is on the Board of Directors of the Cancer Society; Chairman of the Southwest District of the Ohio Hospital Association, and on the Board of Trustees of the Ohio Hospital Association. He is President of the Greater Cincinnati Hospital Council and a member of the Council of the Regional Medical Program. Mr. Mischley's community interests include membership on CORVA's Areawide Health Facilities Committee.

Dennis McClung (Provider—3 year term), Blue Cross of Southwest Ohio (Office), 1351 William H. Taft Rd., Cincinnati, Ohio 45206, 6981 N. Moorfield Drive (Home), Cincinnati, Ohio. Mr. McClung is the Executive Vice President of Blue Cross for Southwestern Ohio and a member of CORVA's Areawide Health Facilities Committee. He is also very active in community and social affairs.

Thomas V. Morrow (Consumer—Ex-Officio with vote), Cincinnati Gas & Electric Company (Office), P.O. Box 960, Cincinnati, Ohio 45201, 1953 Honeysuckle Lane (Home), Cincinnati, Ohio 45230. Mr. Morrow is Manager of the Systems and Methods Department of the Cincinnati Gas & Electric Company. He is currently the President of the Hamilton County Health Planning Association. He was on the Budget Committee of the Community Chest from 1961-69 and Chairman of the Family Life Federation from 1963-69 (Chairman 1967-68). Since 1969 he has been a member of the Executive Board of the Allocations Division of the Community Chest. Some of Mr. Morrow's civic activities include the Walnut Hills High School Parents Association and the Association for Systems Management. He is also active at St. Timothy's Episcopal Church.

Mrs. Phyllis Mosier, R.N. (Provider—1 year term), 114 S. Manchester Street (Home), West Union, Ohio 45693. Mrs. Mosier works as a public health nurse in the Adams County Health Department. She is a member of the West Union Women's Club and the Southwest Tuberculosis and Respiratory Disease Association Board. Mrs. Mosier is Service Chairman of the Adams County Unit of the American Cancer Society.

Marie Nelson, R.N. (Provider—1 year term) St. Luke Hospital of Campbell County (Office), Ft. Thomas, Kentucky 41075, 334 Knollwood Drive (Home, Highland Heights, Kentucky 41076. Mrs. Nelson is Supervisor of the Coronary Care Unit at St. Luke Hospital. She is a member of the Kentucky Nurses Association. Mrs. Nelson is also interested in vocational training and teaches part time at the Northern Kentucky Vocational School.

Sam A. Noblet (Consumer—Ex-Officio with vote), 300 Eastline Drive (Home), Middletown, Ohio 45042. Mr. Noblet is Supervisor of Community Relations for Arneo Steel Corporation and is President of the Butler-Warren Health Planning Association. He is Vice-President of the Senior Citizens' Council and serves on the Board of the Tuberculosis and Respiratory Disease Association, the Industrial Council of the Chamber of Commerce and Multiple Sclerosis.

Marko Paliobagis (Consumer—1 year term), Cincinnati Milacron, Inc. (Office), Cincinnati, Ohio 45209, 4081 McLean Drive (Home), Cincinnati, Ohio 45230. Mr. Paliobagis is very active in Clermont County. He is currently a member of the West Clermont Board of Education, the Health and Welfare Planning Council, the Allocations and Appropriations Committee of the Community Chest, and the CORVA Areawide Environmental Health Committee. He is also active in the Boy Scouts of America. Mr. Paliobagis is a member of the American Institute of Physics, Cincinnati Radiation Society, the Ohio State Academy of Science, the American Association for the Advancement of Science and on Committees of the Society of Automotive Engineers and the American Society of Testing and Materials.

Edward A. Roberto (Provider—1 year term) Brown County General Hospital (Office), 610 S. Pleasant, Georgetown, Ohio. Mr. Roberto is Administrator of the Brown County General Hospital. He is a member of the Brown County Health Planning Association and the Georgetown Chamber of Commerce. His health related activities are many. He is a Fellow with the American College of Hospital Administrators; on the Board of Trustees of the Ohio Hospital Association; a member of the Advisory Council of the Ohio Valley Regional Medical Program; a member of the American Public Health Association and the American Hospital Association; and a Trustee of the Greater Cincinnati Hospital Council. Mr. Roberto is also active in civic affairs being on the Board of Directors of the Georgetown Exempted Village Schools.

Walter H. Roehll, Jr., M.D. (Provider—1 year term), 701 University (Office), Middletown, Ohio 45042, 200 Alamo Drive (Home). Dr. Roehll is Vice President of CORVA's Board of Trustees, a member of the Areawide Community Health Services Committee, and the Areawide Health Facilities Committee. He was past President of the Butler County Branch of the American Heart Association and County Medical Society. He is also Vice President of the Middletown Civic Association.

Louise Ruffin (Consumer—3 year term), 1211 Myrtle Street (Home), Cincinnati, Ohio 45206. Mrs. Ruffin is active in community affairs. She is Business and Social Welfare Chairman of the Metropolitan Community Action Board, and a member of the Social Planning Committee of the Community Chest. Mrs. Ruffin is also active in church and school-related organizations.

Michael J. Ryan, Jr. (Provider—2 year term), Heart Association of Southwestern Ohio, Inc. (Office), 2535 Gilbert Avenue, Cincinnati, Ohio 45206, 4201 Victory Parkway (Home), Cincinnati, Ohio. Mr. Ryan is the Executive Director of the Southwestern Ohio Chapter of the American Health Association and he has been active with the Public Health Federation. In addition, he is a member of CORVA's Areawide Community Health Services Committee.

Eugene L. Saenger, M.D. (Provider—3 year term), Radioisotope Laboratory (Office), Cincinnati General Hospital, Cincinnati, Ohio 45229, 9160 Given Road (Home), Cincinnati, Ohio 45243. Dr. Saenger is Professor of Radiology and Director of the Radioisotope Laboratory at the Cincinnati General Hospital. He is past President of the Public Health Federation, and on the Board of Trustees of the Hamilton County Chapter of the American Cancer Society. Active in community affairs, he is on the Mayor's Advisory Committee on Environmental Health, and CORVA's Areawide Environmental Health Committee. He also has served in various leadership positions with the Community Chest and serves on the Board of Directors, Health Physics Society, and Committee on Nuclear Medicine of the American College of Radiology.

Martin Saidleman, M.D. (Provider—3 year term), 3245 Burnet Avenue (Office), Cincinnati, Ohio 45229. Dr. Saidleman is Director of the Cincinnati Maternal and Infant Care Clinics, and also is active in Pediatric Well-Child Programs throughout the area. He serves on the Clermont County Mental Health/Mental Retardation Planning Council and is active in various OEO Projects.

Sanford S. Scheingold, D.D.S. (Provider—2 year term), University Ave. & Vernon Place (Office), Cincinnati, Ohio, 8560 Kentland Court (Home), Cincinnati, Ohio 45236. Dr. Scheingold is a member of the Health Council of the Community Chest, a member of the Trustees of the Public Dental Society, and a past member of Health Careers. He is also a member of the Big Brothers Association. Dr. Scheingold is interested in community affairs and is a member of CORVA's Areawide Community Health Services Committee.

Mary Schloss (Consumer—3 year term), 975 Marion Ave. (Home), Cincinnati, Ohio. Mrs. Schloss is an Attorney and has many health and community related interests. She is past President and current Executive Committee member of the United Cerebral Palsy; past Vice President of the Community Chest; past Vice President of Community Health & Welfare Council; past Trustee of the United Appeal; and past member of the Allocations Division of the Community Chest. She is a member of the Executive Committee of the Community Action Commission. Mrs. Schloss is past President of the Cincinnati Board of Education, past State President and current National Vice President of the P.T.A.

William B. Selnick, D.O. (Provider—Ex-Officio with vote), % Loveland Clinic (Office), 2nd & East Loveland, Loveland, Ohio 45140, 8700 Shawnee Run Road (Home), Cincinnati, Ohio 45243. Dr. Selnick is Medical Director of the Loveland Clinic. He is very active in community affairs, which include his being Chairman of the Clermont County Health & Welfare Planning Council and Chairman of its Planning Committee; a Board Member of the Greater Cincinnati Hospital Council. He also holds memberships on the Allocations Division and Executive Board of the Community Chest. Dr. Selnick is also a Medical Inspector for Nursing Homes in Clermont County and a member of the Clermont County Community Health Board. He works closely with CORVA on the Areawide Community Health Services Committee.

William P. Sheehan (Consumer—2 year term), Cincinnati AFL-CIO, Central Labor Council (Office), 1015 Vine Street, Cincinnati, Ohio 45202, 626 Joseph Lane (Home), Park Hills, Kentucky 41011. Mr. Sheehan is Executive Secretary-Treasurer of the Cincinnati AFL-CIO Labor Council. He is on the Board of Directors of the Ohio Citizen's Council for Health & Welfare and a former Board member of the Community Health & Welfare Council. Mr. Sheehan is also on

the Board of Trustees of the Community Chest, the Cincinnati Chapter of the American Red Cross, Board of Directors of the Ohio Council on Economic Education, and a member of OKI.

James M. Smith, M.D. (Provider—2 year term), 140 Buckeye Street (Office), Hamilton, Ohio 45011, 6201 Princeton-Glendale Rd. (Home), Hamilton, Ohio. Dr. Smith is a member of the Butler County Mental Hygiene Association, and a member of the Planning Division of the County Board of Health. He is also a member of the Board for the Multiple Sclerosis Society, and past President of the Tuberculosis and Respiratory Disease Association. Dr. Smith is a member of the Board of Trustees of the National United Health Foundation.

S. R. Swope, D.O. (Provider—2 year term), 430 W. Central Epringboro Ave., Franklin, Ohio 45005. Mr. Swope works closely with the Warren County Health Department and is a member of the Executive Board of the Red Cross.

Dora Thomas (Consumer—2 year term), 605 Lincoln Park Drive (Home), Cincinnati, Ohio 45203. Miss Thomas is a Vice President of CORVA's Board of Trustees and a member of the Executive Committee. She is Chairman of the West End Health Center and is active in the Model City's Health Planning Program. In addition, Miss Thomas is a member of the Health Committee of the Community Action Commission.

Emma Thomas (Consumer—2 year term), 22 North Lane (Home), Lebanon, Ohio 45036. Mrs. Thomas is a retired person who is active in community affairs including the Community Action Commission. She is involved in the Butler-Warren Health Planning Association, and is Director of Cancer Supply Workshops. Mrs. Thomas is also interested in political activities. She is a member of the Warren County Republican Central Committee and the National Federation of Republican Women. She works closely with CORVA as a member of the Areawide Community Health Services Committee and is a Trustee of Bessie Davis Community Center.

Jack Thornton (Consumer—3 year term), AT&T-Long Lines (Office), Cynthiana, Kentucky, RR No. 1, Box 327 (Home), Crittenden, Kentucky. Mr. Thornton has worked for the Telephone Company for the past five years, and is currently a communication technician. The preceeding eight years were spent in the U.S. Air Force. Mr. Thornton is very active in Grant County. He is currently President of the Jayees, the Board Booster Club and the Athletic Booster Club. He also serves on the Grant County Volunteer Fire Department.

Albert VanSickle, M.D. (Provider—1 year term), City Building (Office), Monument & High Streets, Hamilton, Ohio 45011. Dr. VanSickle is the present City Health Commissioner for Hamilton. He is a retired Colonel in the U.S. Air Force Medical Corps. He is a past Health Commissioner of Clermont County, Ohio. Dr. VanSickle is past President of the Ohio Valley Health Commissioners Association and the Clermont County Medical Association. Community activities include being a Trustee or Director of the Air Pollution Control League, American Cancer Society-Butler-Hamilton unit, Planned Parenthood, and the Hamilton Safety Council.

Theodore H. Vinke, M.D. (Provider—1 year term), 2421 Auburn Avenue (Office), Cincinnati, Ohio 45219, 2444 Madison Road (Home), Apt. 401. Cincinnati, Ohio 45208. Dr. Vinke is presently a Vice President for CORVA's Board of Trustees. Health affiliations include the U.C. College of Medicine and activities in the Cincinnati Academy of Medicine, as well as Chairman, Medical Advisory Board, the National Foundation, member of the Rheumatism Society and various professional societies.

John Wright (Consumer—2 year term), P.O. Box 596 (Office), Warsaw, Kentucky. Mr. Wright is a County Attorney for Gallatin County, Kentucky. CORVA Board of Trustees:

	Number	Percent
(a) Consumer representatives.....	28	153.8
(b) Provider representatives.....	24	46.2
Total.....	52	100

¹ Includes 3 people in the insurance business; 1 person who has been the attorney for the Dearborn County Hospital for the past 17 years and a member of the American Society of Hospital Attorneys; 1 person—President of Corva's Board of trustees—past president of the greater Cincinnati Hospital Council, chairman of the administrative committee of Bethesda Hospital, a member of the Hamilton County Hospital Commission . . . , and 3 persons who are on the boards of trustees of various hospitals in the area.

Name and address	Consumer or provider	Primary occupation	Affiliations	Reason for selection
Sister M. Bernadette, St. Francis Home, 182 St. Francis Avenue, Tiffin, Ohio.	P.....	Nursing home administrator.	-----	Chairman, Facilities Comm., Seneca County.
Mr. John Gettman, Administrator, Memorial Hospital, 715 S. Taft, Fremont, Ohio.	P.....	Hospital administrator.	-----	Chairman, Facilities Comm., Sandusky County.
Mr. Frank Lorenz, National Bank of Defiance, 414 Second Street, Defiance, Ohio.	C.....	Banker	-----	Chairman, Facilities Comm., Defiance County.
Mr. W. E. M——, 4002 Gallo ??????????? Sandusky, Ohio.	C.....	Retired executive, General Motors.	-----	Retired executive, General Motors.
Miss Ada Mitchell, R.N., Administrator, Williams County General Hospital, 909 Snyder Avenue, Montpelier, Ohio.	P.....	Hospital administrator.	-----	Chairman, Facilities Comm., Williams County.
Mr. Robert Savage, Columbus Mutual Life, Insurance, P.O. Box 2823, Toledo, Ohio.	C.....	Insurance	-----	Chairman, Facilities Comm., Lucas County.

Health Planning Assoc. of Northwest, Ohio (Maumee) Executive Committee.

*Upper Peninsula Areawide Comprehensive Health Planning Association
Marquette, Mich.—Summary local financial contributions*

Zone I health planning council area :

Keweenaw County Board of Commissioners-----	\$67. 92
Intermediate School District (p. 27 and 28)-----	1, 050. 00
P. E. Carmody, L'Anse-----	10. 00

Subtotal ----- 1, 127. 92

Zone II Health Planning Council Area : Mary L. Cretens, M.D.----- 5. 00

Zone III Health Planning Council Area :

Marquette Lutheran Ministerial Association (p. 21)-----	300. 00
Michigan Association of Retarded Children (p. 24)-----	50. 00
Williams Insurance Agency, Ishpeming-----	10. 00
Marquette League of Women Voters (Individual members)-----	15. 50
Mr. & Mrs. Howard Lamb, Marquette-----	10. 00
Mr. & Mrs. Robert Beasley, Marquette-----	15. 00
Miss LaVonne M. Dietsche, Marquette-----	10. 00
S. Busch, Marquette-----	. 50
Mr. Frank Mead, Marquette-----	20. 00
Union National Bank and Trust Company, Marquette (p. 23)-----	200. 00
First National Bank of Negaunee (p. 23)-----	100. 00
First National Bank of Marquette (p. 23)-----	100. 00
Miners First National Bank and Trust Co., Ishpeming (p. 23)-----	125. 00
Peninsula Bank, Ishpeming (p. 23)-----	75. 00
Peters, Larson and Raikko Insurance Co., Marquette (p. 23)-----	25. 00
Anonymous contributor, Marquette (p. 23)-----	2, 000. 00
Northwest Radio Supply, Marquette (p. 23)-----	10. 00

Subtotal ----- 3, 066. 00

Zone IV Health Planning Council Area :

Helen Newberry Joy Hospital-----	\$300. 00
Lake Superior State College (pp. 25 and 26)-----	1, 000. 00
Subtotal -----	<u>1, 300. 00</u>

Upper Peninsula Area :

Blue Cross (Based on letter and last year's contribution (pp. 17 and 18)-----	8, 800. 00
U. P. Office Space (pp. 19 and 20)-----	3, 250. 00
Subtotal -----	<u>12, 050. 00</u>
Grand total-----	<u>17, 548. 92</u>

OMAHA, NEBR., AREA MATCHING FUNDS

Area matching funds for the second operational year will be supplied from broadbased sources.

The applicant accepts the responsibility to obtain these funds. The Finance Committee of the Health Planning Council of the Midlands will actively promote, supervise and carry the immediate responsibility for the fund raising activity, on behalf of and with the backing of United Community Services.

The second operational year will be the period December 1, 1971 through November 30, 1972.

Local matching funds required (50% of proposed total operating budget) are \$88,829.

Proposed funding :

Hospitals, 17 of them are committed to 1.58 cents per patient day in 1971. This should yield in 1972 more than-----	\$20, 000
<i>Nursing homes</i> are potential contributors in 1972 of-----	4, 500

NEBRASKA-IOWA BLUE CROSS

Policy of both is to provide a formula support to 314(b) agencies for CHP based on population and subscribers. Estimated for 1972---	5, 000
--	--------

COMMERCIAL HEALTH INSURANCE COMPANIES

This estimate based on 1970 and 1971 experience-----	3, 500
--	--------

UNITED COMMUNITY SERVICES

Cash and In-kind-----	20, 000
-----------------------	---------

COUNTY GOVERNMENTS

An amount of \$30,000 has been proposed for the total contribution of 11 county governments, this split and allocated on the basis of taxable property value. Collections should total-----	<u>22, 500</u>
Total of tentative figures above-----	<u>75, 500</u>

Other potential givers are medical and dental societies ,hospitals and counties not yet committed and several commercial Health Insurance Companies.

FLINT, MICH.—1972-73 GLS FUNDING SCHEDULE

	Solicited	Pledged	Collected
Genesee Bank.....	\$750	\$750	\$750
Citizens Bank.....	750	750	750
Flint Public Trust.....	1,000		
Industrial Mutual Association.....	1,200	1,200	
City of Flint.....	4,500		
Whiting Foundation.....	3,500		
DeWaters Charitable Trust.....	10,000	5,000	5,000
C. S. Mott Foundation.....	5,000	5,000	5,000
Genesee County government.....	7,500		
Michigan Blue Cross.....	15,000		
Genesee County Model Cities program.....	20,000	¹ 20,000	
Total.....	69,200	32,700	11,500

¹ Pledge letter currently being processed.

COMPREHENSIVE HEALTH PLANNING AGENCY OF SOUTHEASTERN WISCONSIN INC.,
MILWAUKEE, WISC.

BUDGET NOTE A

Funding raising: planning approach

Initial planning is underway for the 1972-1973 fund campaign which will be launched after April 1, 1972. In January and early February, letters of request for financial support were sent to a dozen organizations who have been strong supporters of the Agency in the past and can reasonably be counted upon to continue with support for the coming budget year. The organizations contacted were:

Cash contributions:

Blue Cross.....	\$18,000
Hospital Council of Greater Milwaukee.....	13,400
Blue Shield.....	5,000
Hospitals (Southeast region).....	4,000
McKelvey Foundation.....	5,000
Schlitz Brewery.....	4,000
Northwestern Mutual Life Insurance Co.....	3,000
Washington County.....	2,500
Total	54,900

In-kind contributions:

Time Holding, Inc.....	2,200
Racine County planning for health and social services.....	5,000
Corporate members expense.....	2,500
Total	9,700

Grant total..... 64,600

The Budget, Finance and Operations Committee is charged with the responsibility of assisting with the raising funds of the corporation. On February 8, 1972, the Committee met and recommended the fund raising goals as stated in the

budget. On February 17, 1972, the Board of Directors approved a fund campaign of \$120,000 for the budget year 1972-1973.

In April, 1972, active community leaders in the seven county area will contact county governments, industry, foundations, business and individuals to secure pledges and commitments of financial support for the coming budget year. The fund campaign will end by June 1, 1972.

APPENDIX K

LOCAL MATCHING FUNDS, 1972—COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN (DETROIT)

Total budget, Apr. 1-Nov. 30, 1972.....		\$512, 500
Local matching funds.....		256, 250
Federal funds.....		256, 250
	Anticipated	Pledged
SOURCES OF LOCAL FUNDS		
Provider groups:		
Dentists.....	\$1, 000	
Physicians.....	5, 000	\$50
Blue Cross and hospitals.....	80, 718	80, 718
Nurses.....	3, 000	
Podiatrists.....	500	
Pharmacists.....	1, 000	
Blue Shield.....	20, 000	
Total.....	111, 218	80, 768
United Foundation of Greater Detroit.....	132, 000	132, 000
Other united funds:		
Monroe County United Fund.....	1, 000	
United Fund of St. Clair County.....	1, 000	
Washtenaw County United Fund.....	5, 000	
Total.....	7, 000	
Local governments:		
City of Detroit.....	20, 000	20, 000
Livingston County.....	1, 000	
Macomb County.....	10, 000	10, 000
Oakland County.....	15, 000	
St. Clair County.....	2, 000	
Washtenaw County.....	4, 000	4, 000
Wayne County.....	20, 000	
Total.....	72, 000	34, 000
In-kind contributions:		
Citizens for Better Care.....	10, 000	10, 000
Detroit-Wayne County Health Department merger.....	23, 782	23, 782
Total.....	33, 782	33, 782
Surplus local matching funds, Nov. 30, 1971.....	18, 177	18, 177
Total.....	1 374, 177	298, 727

¹ Total anticipated local match applies to fiscal period Dec. 1, 1971, to Nov. 30, 1972. Actual local amount received during 4-month extension totaled \$78,000; balance remaining \$296,177.

LOCAL INCOME FORECAST, FISCAL YEAR 1971-72

COMPREHENSIVE HEALTH PLANNING COUNCIL OF SPOKANE COUNTY, INC. WASHINGTON AND IDAHO PANHANDLE DISTRICT NO. 1 COMPREHENSIVE HEALTH PLANNING COUNCIL

Spokane County Health District	\$3,000
Mental Health and Mental Retardation Council	3,750
United Crusade and Council	3,750
Washington Blue Cross	4,000
Union Health and Welfare Trust Funds	3,000
Pacific Northwest Bell Telephone	500
Washington Water Power	500
Spokane County Medical Society	500
Carryover local funds April, June	239
Idaho Health District No. 1	5,000
Idaho Blue Cross	1,000
Idaho T.B. Association	1,000
Idaho Cancer Society	1,000
Idaho United Crusade	500
Idaho Hospitals	500
Idaho Medical Society	500
Mining and Industry	1,500
Spokane Community Action Council	3,750
Total	33,989

The *Lower Columbia Region 6-A, Clark, Skamania, and Klickitat Counties, Washington*, because of the high rate of unemployment the past two years, has been designated an Economically Deprived Area. Based on this official recognition by the Regional Economic Development Administration. (Attachments I and II.)

Sources of financial income for 1972-73 is 31% local support and 69% requested federal support.

Public Sector:

Clark County Commissioners. (The County provides office space rent free. The space was rented previously by former tenants for \$200.00 per month.)	\$2,000.00
Klickitat County Commissioners. (The County budgets this amount for health planning as a line item in the county planning budget.)	500.00
Skamania County Commissioners. (A budgeted item in the county budget.)	250.00
Regional Planning Council of Clark County. (A line item is in the 1972 budget for \$4,000.00. It is anticipated this will be increased for 1973.)	4,400.00
Business and Industry. (Alcoa has pledged \$500.00, and other businesses are being contacted.)	1,000.00
Hospitals. (This based on \$5.00 per bed and an outright grant pledged by Kaiser Foundation.)	3,000.00
Clark County Physicians Service. (A pledged amount.)	1,500.00
Health & Welfare Planning Council. (United Good Neighbors allocation to the agency are earmarked for health planning.)	2,880.00

Community response to solicitation has been favorable.

METROPOLITAN COUNCIL

(Twin Cities St. Paul-Minneapolis, Minn.), Dec. 1, 1971, through Nov. 30, 1972

	Total amount required	Source of funds	
		Applicant support and other	Requested from HSMHA
D. Supplies: Office supplies, duplication, printing, etc.....	\$10,000	\$5,000	\$5,000
E. Travel:			
Local trips and mileage at 10 per mile (staff and health board mem- bers).....	3,500	1,750	1,750
Out of area.....	2,500	1,250	1,250
Category total.....	6,000	3,000	3,000
F. Other expenses:			
Institutional services: Data processing (Blue Cross).....	7,500	3,750	3,750
H. Total direct costs of project.....	247,450	123,725	123,725
I. Indirect cost allowance (for HSMHA use only).....	56,100	28,050	28,050
J. Total project costs.....	303,550	151,775	151,775
Sources of other funds:			
A. Applicant's support of direct project costs:			
(1) Applicant's funds.....		61,775	
(2) Other sources (identify each source).....			
Voluntary contributions from hospitals at a rate of not less than \$15 per 1,000 short-term acute patient days provided and \$7.50 per 100 long- term days provided.....		30,000	
United funds and community planning councils.....		20,000	
Area program boards.....		10,000	
Model cities (St. Paul).....		30,000	
Total.....		151,775	

[From (Grant Application) to establish a comprehensive Health Planning Agency and program for Northern New Jersey Bergen, Hudson, Passaic, and Sussex Counties]

(Section 314(B), Public Law 89-749 dated March 15, 1972)

LOCAL SHARE FUND RAISING

The Finance and Budget Sub-Committee of the Areawide Steering Committee, chaired by Mr. Fred Leslie, was charged with overall responsibility for the proposed budget including, of course, the matching local funds. The Finance Committee realized the necessity for broadening the base of the local appeal. This was accomplished through the establishment of the areawide Fund-Raising Committee, chaired by Mr. Malcolm A. Borg of Bergen County. County chairman have been appointed and are functioning in their areas. They are Mr. John Peterson and Mr. John Weiss (co-chairmen) Bergen County, Dr. Richard Franklin, Hudson County, Mr. Fred P. Leslie, Passaic County and Mr. Albert Sweet, Sussex County.

To date, the efforts of this committee have assured commitments of \$17,356 and their activities will continue until the entire local share is obtained. Contributions received at this time show an encouraging pattern. They are broadly based, very diverse and representing not only the health community but industry, civil groups, newspapers, and banks. The list grows daily.

The breakdown of local money as of this date is as follows :

Alexander Summer Co.....	\$80. 00
Chamber of Commerce of Newton.....	25. 00
Garden State Plaza Corp.....	25. 00
Broadway Bank & Trust Co.....	214. 00
Midland Bank & Trust Co.....	133. 00
Garden State National Bank (\$1 per employee approx.).....	500. 00
Peoples Trust Co. of New Jersey.....	900. 00
Citizens First National Bank (\$1 per employee approx.).....	200. 00
The Bergen Evening Record Corp.....	1, 000. 00
National Community Bank.....	700. 00
Kiwanis Club of Newton.....	50. 00
Becton Dickinson & Co.....	1,591. 00
Blue Cross of New Jersey (Estimated, Provisional Amount)....	6, 250. 00
Sussex County (Commit. of \$800.00 Initial Start-Contributions to date).....	425.00
Prudential Insurance Co.....	725. 00
Hoffman-La Roche.....	2, 000. 00
Steelfab Inc.....	28. 00

Hospitals in the four county area have committed an additional \$2,510 through a contribution of \$1 a bed. A list of participating hospitals to date (additional are expected) is found in the Fund Raising Attachments Section: (1). It is the feeling of the committee that substantial additional contributions will be received even as his application is being reviewed. A list of the private organizations contacted thus far in addition to commitment received is contained in the Fund Raising Attachments Section of the application #2.

Private foundations in New Jersey interested in health are being contacted. It is not possible to project an amount of money from this area, however, in the attachments there is a copy of the letter sent to the listed foundations. We have projected a modest amount of support from these twenty-eight foundations. It is hoped that it will be considerably in excess of this estimate. (Attachment #3)

The New Jersey Comprehensive Health Planning Agency is seeking a 1¢ capitation grant for State B Agencies. The northern four counties (Area I) will receive approximately \$20,000 based upon this formula. The possibility of this grant is under review by the state and initial indications are favorable.

The County Boards of Freeholders are being asked to participate in the local funding at a level of 11,500. This is broken down as follows :

HEALTH PLANNING COUNCIL OF GREATER MIAMI VALLEY, DAYTON, OHIO

	Total amount required	Applicant and other	Request from HSMHA
From June 1, 1972, through May 31, 1973:			
Personal services.....	\$117,986	\$54,165	\$63,821
Patient care.....	0	0	0
Equipment.....	0	0	0
Construction.....	0	0	0
Other.....	26,630	12,293	14,337
Trainee costs.....	0	0	0
Total direct costs.....	144,616	66,458	78,158
Requested from HSMHA:			
A. Financial assistance (cash award) (\$78,158).....			
B. Direct assistance (\$.....)			
Indirect cost allowance (leave blank).....			
Total costs (leave blank).....			

	(F), (S), (L), (O)	Matching or cost participation requirements	Other
Sources of funds, applicant and other:			
A. Applicant's funds.....			
B. Other sources (identify each source separately):.....			
Blue Cross.....	L	\$10,680	
United Fund.....	L	23,000	
Dayton Area Hospital Council.....	L	10,000	
County governments.....	L	20,810	
Private health agencies.....	L	1,968	
Matching in kind:			
Dayton Area Hospital Council.....	L	5,900	
United Fund.....	L	3,800	
Dayton Area Council on Alcoholism and Drug Abuse.....	L	1,500	
Travel—Board of committee members at 10 cents per mile.....	L	500	
Payment for services provided by project (fees, collections, etc.).....			
(1) Title XIX (medicaid).....			
(2) Other.....			
Cash.....		66,458	
Total.....		78,158	

HEALTH PLANNING ASSOCIATION OF NORTHWEST, OHIO, MAUMEE, OHIO

TOP 10

	Amount requested	Amount received
Industry:		
Owens-Illinois, Inc.....	\$5,000	\$1,500
Libbey-Owens-Ford Co.....	5,000	3,000
Champion Sparkplug Co.....	5,000	1,000
Owens-Corning Fiberglas.....	2,500	1,500
Toledo Edison.....	2,500	600
Dana Corp.....	2,500	
Anderson's.....	5,000	
General Motors Corp. ¹	2,500	² 1,000
Sun Oil Corp.....	1,000	1,000
Johns-Manville.....		2,500
Insurance companies:		
Aetna.....	7,500	675
Additional.....		340
Total.....		1,015
Blue Cross.....	25,000	² 15,000

¹ These contributions arrived prior to the committee determinants of amount to be requested for fiscal year 1971-72.² Contribution July 6, 1971 for fiscal year 1971-72; \$421 out of the \$1,000 was attributable to Lucas County. (The remainder went to Erie and Defiance Counties.)³ Contribution from Blue Cross was allocated to all 11 counties. Lucas County's share is \$7,666.50.SOUTHEASTERN OHIO HEALTH PLANNING ASSOCIATION, CAMBRIDGE, OHIO
BUDGET JUSTIFICATION

Show justification for specific items or categories listed in the detailed budget for which the need is not self-evident. Justifications should clearly indicate that the items being requested are essential to the achievement of the stated project objectives and the conduct of the proposed procedures.

Source of local funds

A county by county fund raising effort is currently underway to secure the applicant agency share of \$55,843.38 for the second year operational expense of the 5 year planning grant application. By February 24, 1972 a total of \$24,164.29

will be firmly and verbally committed.

A list of pledges follows:

Total local share-----	\$79, 343. 38
<hr/>	
Less donations:	
Office space—Guernsey Memorial Hospital-----	10, 000. 00
E.D.P. and Public Relations Services:	
Bethesda hospital-----	500. 00
Good Samaritan Hospital-----	500. 00
10 Ph. D. Students at O.S.U-----	10, 000. 00
1 Ph. D. Student at C.W.R.U-----	1, 000. 00
Legal Services—Mr. Alfred Zinn, Zanesville-----	1, 500. 00
<hr/>	
Total donations-----	23, 500. 00
<hr/>	
Balance of local share to be in cash pledges-----	55, 843. 38
<hr/>	
Less Cash Pledges received:	
Columbus Blue Cross-----	2, 500. 00
Youngstown Blue Cross-----	2, 500. 00
Private Insurance-----	1, 000. 00
Guernsey Memorial Hospital-----	1, 214. 23
Coshocton County Memorial Hospital-----	1, 618. 97
Barnesville Hospital-----	809. 49
Bellaire Hospital-----	1, 011. 86
Martins Ferry Hospital-----	1, 821. 35
St. John's Hospital-----	1, 416. 60
Bethesda Hospital-----	3, 035. 58
Selby General Hospital-----	404. 74
Marietta Memorial Hospital-----	1, 618. 97
Good Samaritan Hospital-----	4, 452. 18
Harrison Community Health Center-----	760. 32
<hr/>	
Sub-Total Cash Pledges already received-----	24, 164. 29
<hr/>	
Total -----	31, 679. 09
Less increase under consideration by the Columbus and Youngstown Blue Cross Agencies-----	4, 000. 00
<hr/>	
Total -----	27, 679. 09
Southeastern Ohio Health Planning Association County Compre- hensive Health Planning Council Share (1972-73 share, plus 8% increase as authorized by the Board of Trustees; based on popu- lation in each county)-----	27, 679. 09
<hr/>	
FINANCIAL REPORT FOR THE SECOND YEAR ORGANIZATIONAL GRANT—(PROPOSED)—TO SOUTHWESTERN MICHIGAN COMPREHENSIVE HEALTH PLANNING ASSOCIATION, JUNE 15, 1972 THRU JUNE 14, 1973	
Federal share-----	\$26, 600. 00
Local share-----	17, 733. 00
<hr/>	
A-Sources of local matching contributions:	
1. Those who have pledged:	
(a) Michigan Blue Cross-----	8, 332. 00
(b) United Fund—Twin Cities-----	50. 00
<hr/>	
	8, 382. 00
<hr/>	
2. Those who have contributed cash:	
(a) SW Mich. District Nurses Association-----	50. 00
(b) Berrien Springs School District-----	50. 00
(c) Berrien County Crippled Children-----	50. 00
(d) Watervliet Hospital-----	252. 00
<hr/>	
Total cash contributions-----	402. 00
<hr/>	

A-Sources of local matching contributions—Continued

3. Local Match pledged as In-Kind contribution	
(a) Berrien County Health Department-----	\$2, 000. 00
(b) Whirlpool Corporation-----	70. 00
	<hr/>
	2, 070. 000
	<hr/>
4. Total local matching funds 1972-73 grant year-----	10, 854. 00
	<hr/>

B-Local Funds needed to Match the second grant year (proposed) :

Local share-----	17, 733. 00
Less contributions on hand-----	10, 854. 00
	<hr/>
Remainder to be matched-----	6, 879. 00
	<hr/>

1. A local matching funds campaign is currently underway. The following format is anticipated for the remainder of local funds:	
(a) Health Departments-----	1, 000. 00
(b) Medical Societies-----	800. 00
(c) Schools and School Districts-----	1, 000. 00
(d) Businesses and Foundations-----	2, 000. 00
(e) Other In-Kind donations-----	2, 000. 00
	<hr/>
	6, 800. 00

The Board of Trustees discussed each of the problem statements so that they would understand the problems underlying the brief description. Voting for the eight most important problem statements the Board ranked the committee recommendation in the following order:

1. There is a need to improve cooperation among facilities in order to prevent increasing costs due to duplication of services, expensive equipment and inappropriate utilization of facilities.
2. The municipality of planning groups tends to contribute to duplication of effort, multiple and uneven criteria for planning and lack of coordination. At the same time, overall plans are not developed.
3. The majority of consumers are not aware of the full range of health facilities and services available in the tri-county area.
4. No current system exists to identify needed services or gaps in services. The consumer and provider does not have a methodology to weigh alternatives and assess priorities.
5. There is a pressing shortage of general practice physicians within the tri-county area. Very few current physicians are able or willing to accept new patients.
6. Low income families and particularly children of these families do not have access to adequate dental care under the present payment mechanism.
7. *The present payment mechanism for health care services does not contain payment for some services, is often unrealistic and some times contributes to inappropriate utilization. Demand for services often exceeds the resources to cover costs.*
7. The present payment mechanism for health care services does not contain payment for some services, is often unrealistic and some times contributes to inappropriate utilization. Demand for services often exceeds the resources to cover costs.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE (42 CFR PART 51, SUBPART A) GRANTS TO STATES FOR COMPREHENSIVE HEALTH PLANNING

NOTICE OF PROPOSED REVISION OF REGULATIONS

Notice is hereby given that the Administrator, Health Services and Mental Health Administration, with the approval of the Secretary of Health, Education, and Welfare, proposes to revise Subpart A of Part 51 of Title 42, CFR, governing grants to States for comprehensive health planning under section 314(a) of the Public Health Service Act (42 U.S.C. 246(a)), as set out below.

The principal purpose of the revision is to implement, with respect to this program, the Health Services and Mental Health Administration simplified

State plan review system. Under that system, documents which are required to be included in State plans and which currently must be submitted to Health Services and Mental Health Administration headquarters for review will instead be incorporated by reference in the State plans, retained in the States, and there reviewed by staff of the Regional Offices.

In addition, the revised regulations would implement the amendments made to section 314(a) of the Public Health Service Act by section 220 of P.L. 91-515 (84 Stat. 1304), including the requirement that representatives of the Veterans Administration (or of other Federal agencies where there are no Veterans Administration health care facilities in a State) and of regional medical programs be included as members of State health planning councils.

A number of technical and conforming changes are also included.

Interested persons are invited to submit written comments, suggestions, or objections regarding the proposed revision of 42 CFR Part 51, Subpart A, to the Community Health Service, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20852, within 30 days after the date of publication of this notice in the Federal Register. Comments received will be available for public inspection at Room 7-05, Parklawn Building, between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

It is proposed to revise Subpart A of Part 51 to read as follows:

Subpart A—Grants to States for Comprehensive Health Planning

Sec.

51.1 Applicability.

51.2 Definitions.

51.3 Submission of State programs.

51.4 State program requirements.

51.5 State allotments.

51.6 Payments to States.

51.7 Equipment, supplies or personnel in lieu of cash.

51.8 Nondiscrimination on account of race, color, or national origin.

Authority.—The provisions of this subpart issued under secs. 215, 314 of the Public Health Service Act as amended; 58 Stat. 690, 80 Stat. 1180; 42 U.S.C. 216, 246.

§ 51.1 *Applicability.*

The regulations of this subpart apply to grants to assist the States, including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands, in comprehensive and continuing planning for their current and future health needs in terms of health services, health manpower and health facilities, as authorized by section 314(a) of the Public Health Service Act, as amended.

§ 51.2 *Definitions.*

All terms not defined herein shall have the same meanings as given them in the Act. As used in this subpart:

(a) "Act" means section 314 of the Public Health Service Act, as amended (42 U.S.C. 246).

(b) "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved may be delegated.

(c) "State program" refers to the State plan for comprehensive health planning which contains the information, proposals, and assurances submitted by the State agency pursuant to section 314(a) of the Act and the regulations of this subpart.

(d) "State agency" means the single State agency (which may be an inter-departmental agency) designated in the State program for administering or supervising the administration of the State's health planning functions under the State program.

§ 51.3 *Submission of State programs.*

In order to receive funds from an allotment under this subpart, a State must submit to and have approved by the Secretary a State program which incorporates by reference the information and meets the requirements specified in the Act and in the regulations of this subpart. Such program shall be submitted by the State agency officially designated and authorized to administer it and carry out the functions prescribed hereunder. Documents incorporated by refer-

ence become a part of the State program as though fully set forth herein. Such documents must be (a) clearly identified as to subject, date, and location, (b) officially adopted and disseminated in accordance with applicable procedures, (c) made available to the public for inspection, and (d) copies furnished to the Secretary on request.

§ 51.4 *State program requirements.*

(a) *Responsibility of State agency.* The State program must provide that the State agency will either administer or supervise the administration of the activities to be carried out under it. In order to assure adequate supervision by the State agency of the administration of activities under the State program carried out by other agencies, institutions, organizations, or individuals, the State program must incorporate by reference documents showing that the State agency (1) is able to obtain from such other agencies, institutions, organizations, or individuals the data needed for formulation and evaluation of, and accountability for, planning activities; (2) has established methods for performing continuing professional and administrative evaluations of such activities; and (3) is in a position to take such steps as may be necessary to assure that such activities meet Federal and State requirements.

(b) *State health planning council.* The State program must incorporate by reference documents showing that a State health planning council has been established to advise the State agency in carrying out its functions under the approved State program. Council membership shall include representatives of State agencies (other than the designated State agency) and local agencies and of nongovernmental organizations and groups concerned with health (including representation of the regional medical programs established under Title IX of the Act which are included in whole or in part within the State), and one or more representatives of Federal agencies concerned with health: *Provided*, That, if there is located in the State one or more hospitals or other health care facilities of the Veteran's Administration, the membership of the council shall include as an ex officio member the individual whom the Administration of Veteran's Affairs shall have designated to serve on such council as the representative of the hospitals or other health care facilities of such Administration which are located in the State; and the requirement of representation of Federal agencies concerned with health shall be satisfied by the inclusion of such Veteran's Administration representative. *A majority of the council members must be consumer representatives whose major career or occupation is neither the organization, financing, or delivery of health services, nor research in or the teaching of health sciences.* Membership of the council shall generally reflect the various socioeconomic groups and geographic areas of the State. The council shall meet as often as necessary and not less often than twice a year for the purposes of consulting with and advising the State agency with respect to:

(1) The scope of planning activities to be undertaken by the State agency:

(2) The recommendations to be made by the State agency as a result of such activities; and

(3) Necessary review and modifications of the State program.

(c) *Expenditure of grant funds.* The State program must incorporate by reference written policies and procedures for the expenditure of funds under the program, which shall provide that:

(1) The scope of comprehensive health planning will encompass the need for services (including home health services), facilities, and manpower to meet the physical, mental, and environmental health needs of the people of the State, and the financial and organizational resources through which these needs may be met;

(2) Such planning will be concerned with both publicly and privately supported health services and activities;

(3) A method for determining priorities of planning activity will be established to ensure that the most critical planning problems are scheduled for early attention;

(4) Methods will be established for obtaining and utilizing, in the formulation of planning priorities and recommendations, effective and appropriate informational support, including statistical data and, where feasible, social, economic, demographic, and similar base data consistent with those to be utilized for other comprehensive planning activities in the State;

(5) To administer or supervise the administration of the planning functions under the State program and to provide staff assistance to the State health planning council, the State agency will establish positions, including the full

time position of comprehensive health planning director, to be filled by persons with appropriate qualifications: *Provided*, That the Secretary may, in particular cases, approve arrangements for administering or supervising the administration of the State agency's planning activities through other than a full-time director where he finds that such other arrangements will result in the effective administration of such activities;

(6) The State agency will cooperate with and assist in the development of needed regional, metropolitan area and other local area health planning agencies and be prepared to act upon, and to inform the Secretary of its actions with respect to, grant applications under section 314(b) of the Act.

(d) *Encouraging cooperative efforts.* The State program must incorporate by reference written policies and procedures for encouraging cooperative efforts among governmental and nongovernmental agencies, organizations, and groups concerned with health and related services, facilities, and manpower. As a minimum, such policies and procedures must provide methods for:

(1) Coordinating the State agency's planning activities with specialized health planning and other related planning activities, such as the development of mental retardation plans, construction plans for health and medical facilities, community mental health plans, regional medical programs, environmental quality plans, and State physical and economic planning;

(2) Considering the most effective and efficient manner of meeting health needs in the fields of welfare, education and rehabilitation;

(3) Considering the special needs of high-risk population groups for preventive and health care services.

(e) *Federal funds to supplement State funds otherwise available.* The State program must contain satisfactory assurances that Federal funds will not supplant funds that would otherwise be made available by the State for the purpose of comprehensive health planning and that Federal funds will, to the extent practicable, be used to increase the level of non-Federal funds available for such purpose. Substantial compliance with such assurance will be deemed to have been met if the level of non-Federal funds made available to and spent by the State for comprehensive health planning is at least no lower for any fiscal year than it was in the immediately preceding fiscal year, except that the Secretary may also take into consideration the extent to which the level of such funds for any fiscal year may have included funds for an activity of a non-recurring nature.

(f) *Methods of administration.* The State program shall:

(1) Provide for the establishment and maintenance of personnel standards on a merit basis for persons employed by the State in carrying out the State program. Conformity with the Standards for a Merit System of Personnel Administration, 45 CFR Part 70, issued by the Secretary of Health, Education, and Welfare, including any amendments thereto, and any standards prescribed by the United States Civil Service Commission pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (P.L. 91-648; 84 Stat. 1915) modifying or superseding such Standards, will be deemed to meet this requirement as determined by said Commission. Laws, rules, regulations and policy statements, and amendments thereto, effectuating such methods of personnel administration shall be incorporated by reference in the State plan;

(2) Incorporate by reference written policies and procedures for informing interested parties and organizations and the general public about the agency's activities and recommendations;

(3) Contain an assurance that no more than 50 percent of the funds available to the State agency under the State program will be used for contracting with other agencies and organizations to conduct planning functions under the State program without specific approval from the Secretary; and

(4) Incorporate by reference written policies and procedures by which criteria will be developed as a basis for approval or disapproval of applications for areawide health planning project grants under section 314(b) of the Act.

(g) *Reports and records.* (1) The State program must contain an assurance that, in addition to any other reports or records required by the regulations of this subpart or which may reasonably be required by the Secretary under the Act.

(i) The State agency will maintain adequate records to show the disposition of all funds (Federal and non-Federal) expended for activities under the approved State program;

(ii) The Secretary will be provided copies of each recommendation, plan or portion of a plan adopted by the State agency;

(iii) An annual narrative summary of the planning activities undertaken during the preceding year will be submitted to the Secretary; and

(iv) Cumulative expenditure reports on forms prescribed by the Secretary will be submitted within 30 days after the end of the second quarter of any Federal fiscal year and within 60 days after the close of the Federal fiscal year.

(2) All records shall be retained for three years after the close of the fiscal year in which the grant was made. Such records may be destroyed at the end of such three-year period if the State agency has been notified of the completion of the Federal audit by such time. If the State authority has not been so notified by the end of such three-year period, such records shall be retained (i) for 5 years after the close of the fiscal year in which the grant was made or (ii) until the State agency is notified of the completion of the Federal audit, whichever comes first. In all cases where audit questions have arisen before the expiration of such 5-year period, records shall be retained until resolution of all such questions.

(3) The State agency must afford access to the records maintained by it to the Comptroller General of the United States and the Secretary of Health, Education, and Welfare, or their authorized representatives, for purposes of audit and examination.

(h) *Review and modification.* The State program must contain an assurance that the State agency will review and evaluate its approved program at least once annually and submit appropriate modifications to the Secretary. As a minimum, the State agency shall submit annual modifications of the State program which will (1) reflect budgetary and expenditure requirements for the next fiscal year, (2) set forth priorities established for planning activity to be undertaken in the next fiscal year, and (3) update any assurances or other informational requirements included in the State program.

(i) *Program for capital expenditures.* The State program must incorporate by reference written policies and procedures for assisting, through consultation, provision of information, and advice, each health care facility in the State to develop a program of capital expenditures for replacement, modernization, and expansion which is consistent with such overall State plan as has been developed in accordance with criteria established as provided in section 314 (a) (2)(I) of the Act, and shall provide that the State agency furnishing such assistance will periodically review such capital expenditures program of each health care facility in the State and recommend appropriate modification thereof. The assistance and review required under this paragraph may be provided either by the State comprehensive health planning agency itself, or, under such State agency's control and supervision, by a local public or private nonprofit agency, or by another State agency qualified and authorized to provide such assistance and designated in the State program as the agency with the primary responsibility therefor. For the purposes of this section the term "health care facility" includes all hospitals, sanatoriums, nursing homes, and other facilities for the inpatient care of the sick, injured, or disabled, which are licensed or formally approved for such purposes by an officially designated State standards-setting authority, and all public or private nonprofit clinics, health centers, and other facilities a major purpose of which is to provide diagnostic, preventive or therapeutic outpatient health care by or under the supervision of doctors of medicine, osteopathy, or dentistry: *Provided*, That such term shall not include facilities operated by religious groups relying solely on spiritual means through prayer and healing and in which health care by or under the supervision of doctors of medicine, osteopathy, or dentistry is not provided.

(j) *Accounting procedure.* The State program shall incorporate by reference such written fiscal control and fund accounting procedures as are necessary to assure the proper disbursement of and accounting for funds paid to the State under this subpart. Such procedures shall provide for an accurate and timely recording of the receipts of funds from State and Federal sources, of expenditures made from such funds for comprehensive health planning purposes under the State program, and of any unearned balances of Federal funds paid to the State. Controls shall be established by the State agency to ensure that expenditures charged to comprehensive State health planning funds are for allowable purposes and that documentation is readily available to verify the accuracy of such charges.

§ 51.5 *State allotments.*

(a) *Determination.* The allotment of funds for any year to each State shall be the product of

(1) The percentage which the States' weighted population bears to the total of the weighted populations of all States, multiplied by

(2) The amount of appropriated funds available for allotment for the fiscal year; except that the allotment for any State which, as a result of such computation, is less than one percent of the amount available for allotment shall be increased to one percent of such amount and the allotments to other States shall be proportionately reduced as necessary but not below an amount equal to 1 percent. For the purposes of this section, the term "weighted population" means (i) the population of the State (as determined from the latest available estimate from the Department of Commerce) multiplied by (ii) the per capita income of the United States divided by the per capita income of the State (as determined from the latest available estimates from the Department of Commerce).

(b) *Availability.* The funds allotted to any State for a fiscal year shall remain available to the State for obligation in accordance with its approved State program during the fiscal year for which the allotment was made and the succeeding fiscal year. If the Secretary determines that a State will not utilize all of its allotment during the period for which it is available, such balances shall be available for reallocation to other States in accordance with the provisions of subsection 314(a)(3)(B) of the Act. The Secretary will make a determination as to the balances of funds available for reallocation during the last quarter of each fiscal year for which such allotments are available for expenditures by the States and will reallocate such balances as soon as possible after such a determination is made.

§ 51.6 *Payments to States.*

Each State for which a State program has been approved shall from time to time be paid from its allotment for the fiscal year amounts which equal the Federal share, as determined pursuant to section 314(a)(4) of the Act, of expenditures incurred during the period for which such allotment is available. The "Federal share" for any State shall be all or such part of the expenditures for comprehensive State health planning made by or under the supervision of the State agency as the Secretary may determine at the time of his approval of the State program. Payments to a State under this section will be made where practicable through a letter of credit system or, when such a system is not practicable, on the basis of payment requests from the State to meet its current needs. The Secretary will make such adjustments in amounts of payments as may be necessary to correct under or over payments previously made (including expenditures which are disallowed on the basis of audit findings).

§ 51.7 *Equipment, supplies or personnel in lieu of cash.*

At the request of and for the convenience of the State agency, the Secretary may, in lieu of cash payments, furnish to the State agency equipment or supplies or detail to the State agency officers or employees of the Public Health Service when he finds such equipment, supplies, or personnel would be used in carrying out the approved State program. In such case, the Secretary will reduce the payments to which the State agency would otherwise be entitled from its allotment for the fiscal year by an amount which equals the fair market value of the equipment or supplies furnished, and by the amount of the pay, allowances, traveling expenses, and other costs in connection with such detail of officers or employees. For purposes of determining the amount of the expenditures for any fiscal year made in carrying out the approved State program and the Federal share of such expenditures, the costs incurred by the Secretary in furnishing such equipment or supplies and in detailing such personnel to the State agency during the fiscal year shall be considered as expenditures made by and funds paid to the State.

§ 51.8 *Nondiscrimination on account of race, color, or national origin.*

Attention is called to the requirements of Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d; 78 Stat. 252) which provides that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. A regulation implementing such Title VI has been issued by the Secretary of Health, Education, and Welfare with the approval of the President (45 C.F.R. Part 80). Such regu-

lation is applicable to comprehensive State health planning activities which receive Federal financial assistance and requires receipt and acceptance by the Secretary of the applicable documentation set forth therein.

Dated:

Administrator, Health Services and Mental Health Administration.

Approved:

Secretary.

MAY 26, 1972.

Mr. LESLIE P. HEMRY,
President, Health Insurance Association of America,
1701 K Street NW., Washington, D.C.

DEAR MR. HEMRY: The Senate Antitrust and Monopoly Subcommittee is continuing its public hearings on commercial health and accident insurance on June 6, 7 and 8, 1972. Testimony of the Association will be very helpful in assisting the subcommittee to reach a full understanding of the commercial health and accident insurance industry, and its member companies, overall role in helping to develop a health-care system responsive to the needs of all consumers.

It is our understanding that the Association through its Health Insurance Council for Health Area Planning has been assisting the states in comprehensive planning for their current and future health needs. It is our further understanding that representatives of the Health Insurance Council for Health Area Planning and your member companies are serving on the advisory councils of state comprehensive health planning agencies, and are also serving on "B" Agency Advisory Councils. *Would you please furnish us with an up-to-date list of the names of those who are serving on these advisory councils?*

Therefore, we would appreciate receiving your testimony and the list of names on Thursday, June 8, 1972, at 10 a.m., room 2228 New Senate Office Building, Washington, D.C.

You may file a prepared statement of any length which will be printed in full in the hearing record. However, in order to cut growing expenses for transcribing the session and to allow time for dialogue, we must ask that you limit your oral presentation to 15 minutes.

Rules of the Senate require that prepared testimony be submitted well in advance of your appearance. Therefore, we ask that 25 copies of your formal statement be in our office by the close of business Monday, June 5, 1972. An additional 100 copies should be made available for the press on the day of testimony.

Your interest and cooperation are greatly appreciated.

Sincerely,

PHILIP A. HART, *Chairman.*

ALABAMA

"A" agency

Mr. C. Preston Blanks, Jr., Health Planning Administrator, State Department of Public Health, State Office Building, Montgomery, Alabama 36104. Representative: None.

"B" agencies

Mr. W. L. Moore, Jr., Executive Director, The Council for Comprehensive Area-wide Planning for Health Care in the Wiregrass Area, Inc., P.O. Box 1406, Plaza II, Dothan, Alabama 36301. Representatives: Mr. Robert B. Hall, P.O. Box 699, Dothan, Alabama 36301; Mr. John S. Mann, P.O. Box 520, Andalusia, Alabama; Mr. George Proctor, 109 South Three Notch St., Andalusia, Alabama 36420; Mr. W. Earl Register, 403 Madison Avenue, Dothan, Alabama 36301; Mr. W. B. Ward, Route 2, Abbeville, Alabama 36310.

Elizabeth W. Cleino, Ph. D., Director, West Alabama Comprehensive Health Planning Council, P.O. Box 1488, Tuscaloosa, Alabama 35401. Representative: Mr. Walter Owens, 107 Court Square West, Centreville, Alabama 35042.

Mr. Vernon D. Knight, Project Director, Southwest Alabama Health Planning Council, 248 Cox Street, P.O. Box 4533, Mobile, Alabama 36604. Consumer: Mr. Charles E. McNeil, General Agent, Protective Life Ins. Co., Merchants National Bank Bldg., Mobile, Alabama 36601.

Mr. David W. Carter, Administrator, East Central Alabama Health Planning Council, 2900 McGehee Road, P.O. Box 11292, Montgomery, Alabama 36111. Representative: Mr. W. O. Crawford, President, Southern United Life Ins. Co., 116 Catoma Street, Montgomery, Alabama 36104.

Mr. George E. Rice, Executive Director, Community Service Council, Inc., 3600 Eighth Avenue South, Birmingham, Alabama 35222. Representatives: Mr. Wilbur H. Hollins, Executive Vice President, Acamar Realty & Ins. Co., 1630 Fourth Avenue North, Birmingham, Alabama 35203; Mr. Fred Renneker, III, Renneker & Company, Inc., 907 Jefferson Federal Bldg., Birmingham, Alabama 35203; Consumer: Mr. Louis J. Willie, Executive Vice President, Booker T. Washington Ins. Co., P.O. Box 697, Birmingham, Alabama 35201. Community Health Planning Commission: Mr. Olen Roy Ratliff, State Farm Insurance Company, 223½ 2nd Ave. E, Oneonta, Alabama 35121.

ALASKA

"A" agency

Mr. Lawrence J. Sullivan, Health Services Planning Coordinator, Office of Comprehensive Planning, Department of Health & Welfare, Pouch "H", Juneau, Alaska 99801. Representative: None.

"B" agencies

None. Representative: None.

NOTE: See list of current Council members.

ARIZONA

"A" agency

Melvin H. Goodwin, Jr., Ph.D., Director, Arizona Health Planning Authority, 2929 East Thomas Road, Suite 209, Phoenix Arizona 85016. Representative: Mr. C. R. Igoe, Manager, Aetna Life and Casualty, 3003 N. Central Avenue, Suite 900, Phoenix, Arizona 85002.

"B" agency

Mr. George Rosenberg, Executive Director, Health Systems Management, 3813 East 2nd Street, Tucson, Arizona 85716. Representative: Mr. William Alberts, Jr., Harland Insurance Co., P.O. Box 12489, Tucson, Arizona 85711.

ARKANSAS

"A" agency

Mr. Michael Cleary, Director, Health Planning Program, 518 University Tower Bldg., 12th & University, Little Rock, Arkansas 72204. *Consumer or Provider*: Mr. Marshall Driver, Manager, Metropolitan Life Ins. Co., 1614 West Third Street, Little Rock, Arkansas 72201.

CALIFORNIA

"A" agency

David P. Michene, M.D., Acting Chief, CHP, State Department of Public Health, 576 Office Building #6, 744 "P" Street, Sacramento, California 95814. Representative: None.

"B" agencies

Mr. Frank Harland, Executive Dir., Superior California Comprehensive Health Planning Association, 1216 Sheridan Street, Chico, California 95926. Representative: Mr. Leonard Parks, c/o William & Scheer Insurance Agency, 2139 North St., Anderson, California 96007.

Mr. Vic Biswell, Executive Director, Norcoa Health Incorporated, P.O. Box 126, Eureka, California 95501. Representative: None.

Mr. Brian Dobrow, Executive Director, Golden Empire Regional Comprehensive Health Council Inc., 926 J Street, Sacramento, California 95814. Representative: Mr. Byron Graves, Manager—Group Division, Aetna Life Ins. Co., 455 Capital Mall, Suite 435, Sacramento, Calif. 95814.

Mr. Richard Jacobsen, Executive Director, Comprehensive Health Planning Association of San Diego and Imperial Counties, 3211 Jefferson Street, San Diego, California 92110. Representative: Mr. Frank A. Forbes, Metropolitan Area Manager, Group Division, Aetna Life Ins. Co., 1600 First Nat'l. Bank Bldg., San Diego, Calif. 92101.

Mr. Wallace Chipman, Executive Director, Bay Area Comprehensive Health Planning Council, 16 California Street, Suite 302, San Francisco, California 94111. Representative: Mr. Earl Unze, CLU, Senior Account Executive, Pacific Mutual Life Ins. Co., 600 California Street, San Francisco, Calif. 94108; Mr. Andrew A.

Christensen, Supervisor, Claims, Metropolitan Life, 1537 Union Street, Alameda, Calif. 94501.

Mr. Stanley Parry, Executive Director, North San Joaquin Comprehensive Health Planning Assn., 701 East Park Street, Stockton, California 95202. Representative: Mr. Marshall Rojas, 653 S. Filbert St., Stockton, California.

Mr. John Traband, Executive Director, Inland Counties Comprehensive Health Planning Council, P.O. Box 305, 175 W. Fifth Avenue, San Bernardino, California 92402. Representative: Mr. Harold M. Hayes, Insurance Service Associate, 853-A N. Mountain Avenue, P.O. Box 1477, Ontario, California 91762.

COLORADO

"A" agency

Mr. Emmett G. Zerr, Jr., Director, Comprehensive Health Planning, State Planning Office, 700 Capitol Annex, 1375 Sherman Street, Denver, Colorado. Representative: Mr. Charles Lay, Prudential Ins. Co., 2719 South Milwaukee, Denver, Colorado 80210.

DELAWARE

"A" agency

Mr. Harry F. Camper, Dir., Bureau of Comprehensive Health Planning, Department of Health & Social Services, Federal and "D" Streets, Dover, Delaware. Representative: None.

FLORIDA

"A" agency

Mr. Jerome Conger, Chief, Bureau of Comprehensive Health Plan., Div. of Planning & Evaluation, Dept. of Health Rehabilitative Services, 908 South Bronough, Tallahassee, Florida 32304. Representative: Mr. Richard Brooke, Jr., Vice President, Independent Life and Accident, P.O. Box 629, Jacksonville, Fla. 32201.

"B" agencies

Mr. Fred J. Huerkamp, Exc. Dir., Health Planning Council of the Jacksonville Area, Inc., P.O. Box 629, Jacksonville, Florida 32202. Representatives: Mr. Jacob F. Bryan, III, President, Independent Life & Accident, 233 W. Duval St., Jacksonville, Fla. 32202; Mr. Jack Lees, Prudential Ins. Co., P.O. Box 4579, Jacksonville, Fla. 3201; Mr. James D. Renn, treasurer, Peninsular Life Ins. Co., 645 Riverside Ave., Jacksonville, Fla. 32203.

Mr. Wood McCue, Executive Director, Comprehensive Health Planning Council of South Florida, Inc., Suite 312—3000 Biscayne Blvd., Miami, Florida 33117. Representative: Mr. Winston Wynne, CLU, Connecticut General Life, 2250 Douglas Road, Coral Gables, Fla. 33134.

Mr. John H. Schill, Acting Director, Northwest Fla. Comprehensive Health Planning Council, Inc., 21 South Tarragona Street, Pensacola, Florida 32502. Representative: None.

GEORGIA

"A" agency

Eugene J. Gillespie, M.D., Director, Office of Comprehensive Health Planning, Georgia Department of Public Health, 1280 West Peachtree Street, N.W., Atlanta, Georgia 30309. Representative: None.

"B" agencies

Raphael B. Levine, Ph. D., Director, Comprehensive Health Planning, Metropolitan Atlanta Council for Health (MACHealth), 1000 Glenn Bldg., 120 Marietta St., N.W., Atlanta, Georgia 30303. Representative: Mr. Gary Cutini, V.P., Marketing and Sales, Life Ins. Co. of Georgia, Life of Georgia Bldg., 600 West Peachtree Street, Atlanta, Georgia 30308.

Mr. Charles Moeller, Director, Coastal Area Planning and Development Commission, P.O. Box 1316, Brunswick, Georgia 31520. Representative: Mr. Virgil Ramson, 2107 Willet St., Brunswick, Georgia.

HAWAII

"A" agency

Mrs. Sylvia L. Levy, Director, Comprehensive Health Planning, State Department of Health, Kinan Hale, P.O. Box 3378, Honolulu, Hawaii 96801. Consumer: Richard Hager, Mgr., Aetna Life & Casualty, P.O. Box 1556, Honolulu, Hawaii.

"B" agencies

None.

IDAHO

"A" agency

John D. Cambareri, Ph. D., Director, Comprehensive Health Planning, Department of Health, 160 State Office Bldg., 650 West State Street, Boise, Idaho 83707. Representative: Mr. Joseph E. Karpach, Equitable Life Assurance, P.O. Box 8048, Boise, Idaho 83707.

"B" agencies

Mr. Dennis Caldwell, Director, Treasure Valley Areawide Comprehensive Health Planing Agency, Boise State College, 1907 Campus Drive, Boise, Idaho 83707.

Sister Helen Frances, Chairman, North Central Idaho Comprehensive Health Planning Agency, P.O. Box 816, Lewiston, Idaho 83501.

ILLINOIS

"A" agency

Albert Snoke, M.D. Executive Dir., Office of Comprehensive Health Planning, 525 West Jefferson—Suite 320, Springfield, Illinois 62706. Representative: Mr. Dan Bannister, President, Horace Mann Educators, 216 East Monroe, Springfield, Illinois 62701.

"B" agencies

Mr. James Phillips, Ex. Dir., Comprehensive Health Planning Inc., 600 S. Michigan, Suite 1310-1315, Chicago, Illinois 60605. Representative: None.

Mr. Duane Benson, Rock Island-Scott Health Planning Council, c/o Miss Phyllis Biedess, 404 Main Street, Davenport, Iowa 52801. Representative: None.

Dr. John Clarno, Tri-County Comprehensive Health Planning Council, 509 Miller Avenue, Peoria Heights, Ill. 61613. Representative: None.

Mrs. William E. Adams, Council for Community Services, 304 North Main Street, Rockford, Illinois 61101. Representative: None.

INDIANA

"A" agency

Harry D. Offutt, Jr., M.D., Director, Comprehensive Health Planning, Indiana State Board of Health, 1330 West Michigan Street, Indianapolis, Indiana 46206. Representative: Glenn W. Sample, V.P. and Secretary, Indiana Farm Bureau, Inc., 130 East Washington St., Indiana polis 46204.

"B" agency

Mr. Kipton Kaplan, Ex. Dir., Northwest Indiana Comprehensive Health Planning Council, 8145 Kennedy Avenue, Highland, Indiana 46322. Representative: None.

IOWA

"A" agency

Mr. Benjamin Yarrington, Director, Office of Comprehensive Health Planning, State Department of Health, Lucas State Office Bldg., 3rd. Fl., Des Moines, Iowa 50319. Representative: Mr. Harry Graham, Director, Health Insurance Development Bankers Life Ins. Co., 711 High Street, Des Moines, Iowa 50307.

KANSAS

"A" agency

Mrs. Norma Satten, Coordinator, Comprehensive Health Planning Program, State Board of Health, State Office Bldg., Rm. 540E, Topeka, Kansas 66612. Representative: None.

KENTUCKY

"A" agency

Mr. Stawn W. Taylor, M.A., M.P.H., Director, Office of Comprehensive Health Planning, 275 East Main Street, Frankfort, Kentucky 40601. Representative: Senator Clyde Middleton, New York Life Insurance, Covington, Kentucky.

"B" agencies

Mr. Alfred Quartin, Exec. Dir., Blue Grass Comprehensive Health Planning Council, 330 Waller Avenue, Lexington, Kentucky 40504. Representative: Mr. Ollie J. Arnett, Arnett Ins. Co., Salyersville, Kentucky.

Mr. Donald T. Faigle, Executive Director Falls Region Health Council Inc., 702 Portland Federal Bldg., Louisville, Kentucky 40202. Representative: Mr. Preston P. Joyce, Jr., Vice President, Commonwealth Life Ins. Co., Louisville, Kentucky 40202.

LOUISIANA

"A" agency

Mr. Jack B. Parker, Dir., Comprehensive Health Planning, Interdepartmental Health Policy Commission, Room 414, 150 N. Third Street, Baton Rouge, Louisiana 70801. Representative: Mr. Frank R. Spittler, Aetna Life Ins. Co., 2025 Canal Street, New Orleans, La. 70112.

"B" agencies

Mr. George A. Roundtree, Executive Director, Louisiana Capital Area Health Planning Council, Suite 18, 1986 Dallas Drive, Baton Rouge, Louisiana 70806. Representatives: Mr. Joseph H. Baynard CLU, The Guardian Life Ins. Co. of America, P.O. Box 66375, Baton Rouge, La. 70806; Mr. S. J. Bailey, Mgr. The Travelers Ins. Co., 401 Laurel Street, Baton Rouge, La. 70801.

Martin J. Ducote, M.D., Acadiana Health Planning Council, 604 St. Landry Street, Lafayette, Louisiana 70501. Representatives: Mr. Ernie Broussard, Estherwood, La. 70534; Mr. William O. Walker, 103 Robert Drive, Lafayette, La. 70501; Mr. Harold P. Robicheaux, 215 Sanders Street, Franklin, La. 70538.

Mr. Robert T. Jones, Exec. Dir., New Orleans Area Health Planning Council, 802 Masonic Temple Bldg., 333 St. Charles St., New Orleans, La. 70130. Representative: Mr. Robert Demmons, Pan American Life Ins. Co., P.O. Box 60219, New Orleans, La. 70160.

A. A. Bullock, M.D., President, Northwest Louisiana Areawide Health Planning Council, 2748 Virginia Avenue, Shreveport, Louisiana 71103. Representative: None.

Mr. Gordon R. Denker, President, CENLA Health Planning Council, P.O. Box 328, Alexandria, Louisiana 71301. Representatives: Mr. Ben Johnson, Pres., Winnfield Life Ins. Co., 308 North Street, Natchitoches, La.; Mr. Reginald Iathron, 1308 Dorchester Drive, Alexandria, La.; Mr. Dan Brocato, Suite 16, 725 MacArthur Dr., Alexandria, La.; Mr. Brian Duke, P.O. Box 4226, Alexandria, La.

MAINE

"A" agency

Mr. Mark R. Knowles, MPH, Director, Maine Dept. of Health & Welfare; State House, Augusta, Maine 04330. Representative: Mr. Howard Shirley, Prudential Ins. Co., 169 Union Street, Bangor, Maine 04401.

"B" agencies

Mr. Stanley Hanson, Executive Director, Southern Maine Comprehensive Health Association, 583 Forest Avenue, Portland, Maine 04101. Representative: Mr. Robert E. Cash, Second Vice President, Individual Insurance Services, Union Mutual Life Ins. Co., Box 548, Portland, Maine.

Mr. Richard Hooper, Executive Director, Tri-County Health Planning Agency, 460 Main Street, Lewiston, Maine 04240. Representative: None.

Mr. Burt Sheehan, Kennebec Valley Regional, Health Agency, P.O. Box 728, Waterville, Maine 04901. Representative: Mr. William Lawry, President, Burgess and Lawry Ins. Agc.

Mr. Benjamin C. Patch, Jr., Executive Director, Penobscot Valley Regional Health Agency, P.O. Box 672, 160 Broadway, State Street, Bangor, Maine 04401. Representatives: Mr. Leon F. Higgins II, Vice President, D. S. Higgins & Sons, Ins., 155 State Street, Bangor, Maine 04401; Carlton King, President & Treasurer, Maurice C. King Ins. Ag., 234 Wilson St., Brewer, Maine 04412; G. Howard Shirley, Prudential Ins. Co. of Am., 168 Union St., Bangor, Maine 04401.

"A" agency

Mr. Edward M. Jackson, Executive Director, Aroostook Health Services Development, Inc., Box 89, Presque Isle, Maine 04769. Representative: Mrs. Louise McGee, Secretary-Treasurer, H. O. Perry & Son Co., 183 Main Street, Fort Fairfield, Maine 04742.

MASSACHUSETTS

"A" agency

Mrs. Helen G. O'Meara, Director, Comp. Health Planning, Office of CHP, Leverett Saltonstall Bldg., 100 Cambridge Street, Boston, Massachusetts 02202.

Consumer or provider: Mr. Bertram N. Pike, Vice President, John Hancock Mutual Life Insurance Co., 200 Berkley St., Boston, Massachusetts.

"B" agency

Mr. W. Grant Heggie, Jr., Executive Director, Western Massachusetts Health Planning Council Inc., 655 Page Boulevard, Springfield, Massachusetts 01104. Representative: Mr. George E. Hopkins, Second Vice President, Massachusetts Mutual Life, 1295 State St., Springfield, Mass. 01101.

Miss Ann M. McGrath, Executive Director, Comprehensive Health Planning Council of Central Massachusetts, Inc., 116 Belmont Street, Worcester, Massachusetts 01605. Representative: Mr. Francis M. Killion, Jr., Group Administrator, State Mutual Life Assurance Company, 440 Lincoln St., Worcester, Massachusetts.

MICHIGAN

"A" agency

Mr. Michael Cook, Acting Director, Office of Comprehensive Health Planning, Lewis Case Bldg., Lansing, Michigan 48913. Representative: Mr. H. J. McLaurin, President, McLaurin and Company; Mr. John E. Mellen, President, Michigan Life Ins. Co.

"B" agencies

Mr. Philip E. Van Heest, Director, Areawide Comprehensive Health Planning Unit, 500 Commerce Bldg., Grand Rapids, Michigan 49502. Representatives: Mr. Douglas E. Jenks, State Farms Ins. Agent, Belding, Michigan; Mr. Donald Pierce, Pierce & Rumble Ins. Agency, Plainwell, Michigan 49080.

Mr. Gordon Labuhn, Exec. Dir., Upper Peninsula Areawide Comprehensive Health Planning Assn., 504 W. Magnetic, Marquette, Michigan 49855. Representative: Mr. John Clements, Clements Insurance Agency, L'Anse, Michigan 49946.

Mr. Terence E. Carroll, Executive Director, Comprehensive Health Planning Council of Southeastern Michigan, 1300 Book Bldg., Detroit, Michigan 48226. Representative: Mr. Brian Boyle, District Claims Manager, New England Mutual Life Ins. Co.

MINNESOTA

"A" agency

Dr. Ellen Z. Fifer, Director, Comprehensive Health Planning, State Planning Agency, 603 Capitol Square Building, 550 Cedar Street, St. Paul, Minnesota 55101. Representative: Mr. David Haskin, Vice-President, Minnesota Mutual Ins. Co., Victory Square, 345 Cedar Street, St. Paul, Minnesota 55101.

"B" agencies

Mr. John Prince, Exec. Dir., Central Minnesota Health Planning Council, 601 Medical Arts Bldg., St. Cloud, Minnesota 56301. Representatives: Mr. Jeff Hennes, Monarch Life Ins. Co., 712 N.E. Riverside, St. Cloud, Minnesota, 56301; Mr. Keith Maurer, Mutual Service Co., 1400 St. Germain, St. Cloud, Minnesota 56301.

Mr. Steve Collins, Exec. Dir., Min-Dak Areawide Comprehensive Health Planning Council, 200 5th Street, Moorhead, Minnesota 56560. Representative: Mr. Hale Laybourne, 301 8th Street S., Fargo, North Dakota 58102.

Mr. Jens Dale, Chairman of the Board, Agassiz Health Planning Council, 714 Minnesota Avenue, Bemidji, Minnesota 56601. Representative: None.

Mr. Gaylord Bridge, Executive Director, Arrowhead Region Planning Council, for Health Facilities & Services, 900 Alworth Bldg., Duluth, Minnesota 55802. Representative: None.

Mr. Donald Ardell, Dir., Metropolitan Council, 101 Capitol Square Bldg., 550 Cedar Street, St. Paul, Minnesota 55101. Representative: None.

MISSISSIPPI

"A" agency

Stephen L. Moore, M.D., M.P.H., Director, Comprehensive Health Planning, Federal-State Program, Office of the Governor, 510 Lamar Life Bldg., Jackson, Mississippi 39201. Representative: Mr. Robert Gaylor, Manager, Group Dept., Travelers Ins. Co., 200 East Capitol Street, Jackson, Mississippi 39201.

"B" agency

Mr. John W. Gill, Executive Director, Southwest Mississippi Council, P.O. Box 686, McComb, Mississippi 39648. Representative: Mr. Billy Ray Jones, Lincoln National Life Ins. Co., 612 Delaware Avenue, McComb, Mississippi 39648.

MISSOURI

"A" agency

Mr. Edward J. Peloquin, Dir., Comprehensive Health Planning Off., Department of Community Affairs, 505 Missouri Boulevard, Jefferson City Missouri 65101. Representative: None.

"B" agencies

Mrs. Evelyn Axtell, Chairman, Green Hills CHP Council, Court House, Trenton, Missouri 64683. Representative: Mr. Don Shuey, Unionville, Missouri.

Mr. Robert Parker, Dir., Alliance for Regional Community Health Incorporated, 915 Olive Street, St. Louis, Missouri 63101. Representatives: Armand C. Stalnaker, 35 York Drive, St. Louis, Missouri; Mrs. Royal Kendall, 620 N. Matter, Columbia, Missouri.

Mr. Kenneth D. Bopp, Executive Director, Mid-America Comprehensive Health P. Ag., 320 East 10th Street, Kansas City, Missouri 64106. Representatives: Mr. Charles M. Hart II, Mutual Benefit Life Ins. Co., 1000 Fairfax Bldg., Kansas City, Missouri 64105; Mr. William T. Orr, BMA Tower—Pen Valley Park, Kansas City, Missouri 64141.

Mr. Thomas Kahl, Dir., Northeast Missouri Health and Welfare Council, Inc., Comprehensive Health Planning, P.O. Box 949, Kirksville, Missouri 63501. Representative: Mr. Raymond Shaw, MFA Insurance Co., Lancaster, Missouri.

Father Wally Ellinger, Chairman, Bootheel Comprehensive Health Planning, c/o Bootheel Regional Planning Commission, Malden, Missouri 63869. Representative: Mr. George Carter, Shelton Bldg., Kennett, Missouri 63857.

MONTANA

"A" agency

Mr. Robert Johnson, Dir., Office of Comprehensive Health Planning, State Department of Health, 35-11th Avenue, Helena, Montana 59601. Representative: None.

NEBRASKA

"A" agency

Mrs. Calista C. Hughes, Director, Comprehensive Health Planning, P. O. Box 94601, Capitol, Lincoln, Nebraska 68509. Representative: Mr. Paul F. Schneider, Vice President, Mutual of Omaha, 33rd and Farnam, Omaha, Nebraska 68131.

"B" agency

Mr. Hal G. Perrin, Executive Director, Health Planning Council of the Midlands, 1805 Harney Street, Omaha, Nebraska 68102. Representative: Mr. Paul F. Schneider, Vice President, Mutual of Omaha, 33rd. and Farnam, Omaha, Nebraska 68131.

NEVADA

"A" agency

Mr. Thomas E. Wilson, Office of the Governor, 208 North Fall St., Carson City, Nevada 89701. Representative: None.

"B" agency

Mr. Richard Nutley, Planning Director, Clark County Areawide Comprehensive Health Planning Association, 625 Shadow Lane, P. O. Box 4426, Las Vegas, Nevada 89106. Representatives: Mr. Bert J. Leavitt, 5705 Heron Avenue, Las Vegas, Nevada; Mr. Dave Branch, 3301 Civic Center Drive, North Las Vegas, Nevada.

NEW HAMPSHIRE

"A" agency

Desmond O'Hara, M.P.H., Director, Office of Comprehensive Health Planning, Department of Health & Welfare, 2½ No. Main Street, Concord, New Hampshire 03301. Representative: Mr. Arthur J. Card, V.P., William G. Parker Co., Inc., 814 Elm Street, Manchester, New Hampshire 03101.

"B" agency

Mr. Robert F. Donovan, Executive Director, Mid-Merrimack Health Planning Council, Inc., 815 Elm Street, Manchester, New Hampshire 03101. Representative: Mr. Frederick W. Griffin, The Insurance Center, 1195 Elm Street, Manchester, New Hampshire 03101.

NEW JERSEY

"A" agency

J. Robert Lackey, M.S.P.H. Director, Comprehensive Health Planning Agency, State Dept. of Health, P.O. Box 1540, Trenton, New Jersey 08625. Representative: None.

"B" agencies

Dr. Edward Ornaf, Chairman, Comprehensive Health Planning Agency of Southern New Jersey, Box 1890, Haddonfield, New Jersey 08033. Consumer or Provider: Mr. George Gersinger, Insurance Executive, Prudential Ins. Co., North Sharp Street, Millville, New Jersey.

Mr. William Lowery, Executive Director, Hospital and Health Council of Metropolitan New Jersey, Inc., 2 Park Place, Newark, New Jersey 07108. Representative: Mr. Richard Melman, Vice President and Associate Actura, Prudential Plaza, Newark. New Jersey 07101.

NEW MEXICO

"A" agency

Mr. George T. Olson, Director, Comprehensive Health Planning, New Mexico State Planning Office, State Capitol, Fourth Floor, Santa Fe, New Mexico 87501. Representative: None.

"B" agency

Mr. John S. Glass, Exec. Dir., North Central New Mexico Comprehensive Health Planning Council, P.O. Box 599—207 Shelby Street, Santa Fe, New Mexico 87501. Representative: Mr. Benny D. Bachicha, P.O. Box 4785, Santa Fe, New Mexico 87501.

NORTH CAROLINA

"A" agency

Mr. Elmer M. Johnson, Director, Office of Comprehensive Health Planning, 116 West Jones Street, Raleigh, North Carolina 27602. Representative: None.

"B" agencies

Mr. R. Grant Hurst, Executive Director, United Community Services, 301 South Brevard Street, Charlotte, North Carolina 28202. Representative: Mr. W. Peterson, Lincoln Life Ins. Co., 1373 East Morehead St., Charlotte, North Carolina 28204.

Robert C. Moffatt, M.D., Acting Exec. Director, Mountain Ramparts Health Planning Inc., Doctors Bldg., Asheville, North Carolina 28801. Representative: None.

Mr. George Stockbridge, Executive Secretary, Health Planning Council for Central North Carolina, Home Security Bldg., 505 West Chapel Hill Street, Durham, North Carolina. Representatives: Mr. George Watts Hill, Chairman, Exec. Committee, Home Security Life Ins. Co., P.O. Box 410, Durham, North Carolina; Mr. Maceo A. Sloan, North Carolina Mutual Life Ins. Co., Mutual Plaza, Durham, North Carolina; Dr. Charles D. Watts, Vice President and Medical Director, North Carolina Mutual Life Ins. Co., Durham, N.C.

NORTH DAKOTA

"A" agency

Mr. Edward Synieski, Director, Division of Health Planning, State Department of Health, State Capitol, Bismarck, North Dakota 58501. Consumer: Mr. Carl H. Cummings, Pioneer Mutual Life, 203 North Tenth, Fargo, North Dakota 58102.

"B" agencies

Mr. Almon B. Strong, Executive Director, North Central Area Health Planning Council, Room 505, 1st Avenue Bldg., Minot, North Dakota 58701. Representative: Mr. Jay L. Monicken, North American Life & Cas. Co., Room 501, First Ave. Bldg., Minot, North Dakota 58701.

Mr. Hugh Sanders, Exec. Dir., North Dakota South Central Health Planning Council, 219 No. Seventh St., Bismarck, North Dakota 58501. Representative: Mr. Alfred Riskedahl, Steele, North Dakota 58482.

OHIO

"A" agency

Mr. Sewall Milliken, Chief, Office of Comprehensive Health Planning, Ohio Department of Health, 450 East Town Street, P.O. Box 118, Columbus, Ohio 43216. Representative: None.

"B" agencies

Mr. Samuel S. Long, Executive Director, Health Planning Association of Northwest Ohio, 2243 Ashland Avenue, Toledo, Ohio 43620. Representative: Mr. Clifford Cunningham, Cunningham Insurance Agency, 135 S. Fulton, Wauseon, Ohio.

Mr. Gordon Smith, Executive Director, The Comprehensive Health Planning Association of Greater Ottawa Valley, 616 S. Collett Street, Lima, Ohio 45805. Representative: None.

Mr. Stephen F. Davie, Executive Director, Health Planning Council of the Greater Miami Valley, 349 West First Street, Dayton, Ohio 45502. Representative: None.

Mr. James Sandmann, Executive Director, Health Planning Association of the Central Ohio River Valley, Almas-Doepke Bldg., 222 East Central Parkway, Cincinnati, Ohio 45202. Representatives: Mr. David J. Heggem, Union Central Life Ins. Co., P.O. Box 179, Cincinnati, Ohio 45229; Thomas J. Klinedinst, Thomas E. Wood Insurance, Carew Tower, Cincinnati, Ohio 45202.

Mr. Delbert L. Pugh, Executive Director, Mid-Ohio Health Planning Federation, 1666 East Broad St., P.O. Box 2239, Columbus, Ohio 43216. Representatives: Mr. John E. Fisher, Nationwide Ins. Co., 246 North High Street, Columbus, Ohio 43215; Mr. Norman Sleigh, State Farm Ins. Co., 1440 Granville Road, Newark, Ohio 43055.

Mr. Lee J. Podolin, Executive Director, Metropolitan Health Planning Corp., 908 Standard Bldg., Cleveland, Ohio 44113. Representative: None.

Mr. Alden C. Cummins, Executive Director, Mahoning Valley Health Planning Assn., 15 Colonial Drive Suite 22, Youngstown, Ohio 44505. Representative: None.

Mr. Thomas Linstrom, Executive Director, Seven County Health Planning Council, 201 East Liberty St., Wooster, Ohio 44691. Representative: None.

Mr. J. E. Farrington, Executive Director, Ohio Valley Health Services Foundation Inc., Security Bank Bldg., Room 504, S. North Court Street, P.O. Box 845, Athens, Ohio 45701. Representatives: Mr. John G. Harding, Insurance, 2104 South Tenth, Ironton, Ohio 45638; Mr. Dwight Rutherford, Insurance and Real Estate, Security Bank Bldg., Athens, Ohio 45701.

Mr. Arthur Ziegler, Executive Director, Summit-Portage County Comprehensive Health Planning Agency, Inc., 326 Locust Street, Akron, Ohio 44302. Representative: None.

Mr. Roger Barnaby, Executive Director, Southeastern Ohio Health Planning Assn., Health Planning Agency, 127 South 10th Street, P.O. Box 748, Cambridge, Ohio 43725. Representative: None.

OKLAHOMA

"A" agency

Mr. Jack Boyd, Director, Oklahoma State Health Planning Agency, Office of the Governor, Division of the Budget, 4545 Lincoln Boulevard, Room 20, Oklahoma City, Oklahoma 73105. Consumers: Mr. Lawrence L. Hoecker, Chairman of the Board of Trustees, American General Life Ins. Co., 621 North Robinson Avenue, Oklahoma City, Oklahoma 73102; Mr. William Kohl, Manager, Aetna Life Insurance Company.

"B" Agencies

Mr. Harold D. Watson, Director of Health Planning, Kiamichi Economic Development District of Oklahoma, Eastern Oklahoma State College, Wilburton, Oklahoma 74578. Representative: Mr. Don Griggs, Independent Ins. Agent; 211 East Duke, Hugo, Oklahoma.

OREGON

"A" agency

Mr. S. Charles Bocci, Coordinator, Comprehensive Health Planning, Executive Department, Public Service Bldg., Room 306, Salem, Oregon 97310. Representative: Mr. David Green, The Insurance Mart, 442 Sixth Street, Madras, Oregon 97741.

"B" agencies

Mr. Richard Rix, Executive Director, Comprehensive Health Planning Assn. for Metropolitan Portland Area, Marquam Plaza Bldg., Room 102, 2525 S.W. 3rd. Avenue, Portland, Oregon 97201. Consumer: Mr. A. G. Lindstrand, Administrator, Aetna Ins. Co., 522 S.W. Fifth Avenue, Portland 97204.

PENNSYLVANIA

"A" agency

Mr. Henry V. Walkowiak, Director, Office of Comprehensive Health Planning, Pennsylvania Dept. of Health, Health and Welfare Bldg., P.O. Box 90, Harrisburg, Pennsylvania 17120. Representative: None.

RHODE ISLAND

"A" agency

Joseph A. Yacovone, D.M.D., M.P.H., Executive Director, Office of Comprehensive Health Planning, Davis Street, Providence, Rhode Island 02908. Representative: Mr. William V. Copeland, Claims Manager, Liberty Mutual Ins. Co., 100 Medway Street, Providence, Rhode Island.

SOUTH CAROLINA

"A" agency

Mr. S. J. Ulmer, Jr., Director, Office of Comprehensive Health Planning, State Board of Health, 2600 Bull Street, Columbia, South Carolina 29201. Representatives: Mr. J. B. Johnson, Jr., Liberty Life Ins. Co., Greenville, South Carolina 29601; Mr. Joe B. Davenport, Insurance, P.O. Box 142, Anderson, S.C. 29621; Mr. J. B. Johnson, Jr., Chairman, S. C. Ins. Council, Liberty Life Ins. Co., Greenville, S.C. 29621.

SOUTH DAKOTA

"A" agency

Director, Division of Comprehensive Health Planning, Office of the Governor, East Office Bldg., Pierre, South Dakota 57501. Representative: None.

TENNESSEE

"A" agency

Mr. Michael T. Bruner, Director, Office of Comprehensive Health Planning, Tennessee Dept. of Public Health, 105 Capitol Towers, Nashville, Tennessee 37219. Consumer: Mr. Dudley Porter, Jr., Vice President, Provident Life & Accident Ins., Chattanooga, Tennessee.

"B" agencies

Mr. C. F. Anderson, Jr., Director, Georgia-Tennessee Regional Health Commission, 425 James Bldg., Chattanooga, Tennessee 37402. Consumers: Mr. Stanyarne Burrows, Jr., Vice President, Volunteer State Life Ins. Co., Volunteer Bldg., Chattanooga, Tennessee 37402; Mr. Bernard T. Hurley, Jr., Agency Vice President, Provident Life and Accident Insurance Co., Fountain Square, Chattanooga, Tennessee 37401.

Mr. Norman Casey, Director, Mid-South Medical Center Council for Comprehensive Health Planning, Inc., Suite 1200, Medical Center Bldg., 969 Madison Avenue, Memphis, Tennessee 38104. Representatives: Mr. Edward B. Ballou, Jr., Agent, New York Life Ins. Co., 1610 First National Bank Bldg., Memphis, Tennessee 38103; Mr. J. W. Brakebill, J. W. Brakebill Agency, Inc., 2108 First National Bank Bldg., Memphis, Tennessee 38103; Mr. J. T. Chandler, Sr., Supervisor, Universal Life Ins. Co., 480 Linden Avenue, Memphis, Tennessee 38126.

TEXAS

"A" agency

Marion R. Zetzman, M.P.H., Act. Director, Office of Comprehensive Health Planning, Office of the Governor, 403 West 13th Street, Austin, Texas 78701. Representative: None.

"B" agencies

Mr. E. L. Melin, Director of Health Planning, Panhandle Regional Planning Commission, Room 404, Amarillo Bldg., Amarillo, Texas 79101. Representative: Mr. Nelson E. Cash, Nelson E. Cash and Associates, 3200-B S. Georgia, Amarillo, Texas 79169 (Great Southern Ins. Co. rep.).

Mr. Lewis R. Burton, Coordinator of Urban Research and Services, The El Paso Council of Governments, 1019 Southwest Center Bldg., El Paso, Texas 79901. Representative: None.

Mr. Randall Hampling, Director of Health Planning, Nortex Regional Planning Commission, 2414-9th Street, Wichita Falls, Texas 76301. Representative: None.

Mr. James F. Ridge, Executive Director, Concho Valley Council of Governments, Room 505, 7 West Twohig Bldg., San Angelo, Texas 76901. Representative: None.

Mrs. Paula Ricci, Director of Regional Services, Central Texas Council of Governments, P.O. Box 729, Belton, Texas 76513. Representative: None.

UTAH

"A" agency

Mr. Norman G. Angus, Director, Office of Comprehensive Health Planning, 888 So. 2nd. E., Salt Lake City, Utah 84111. Consumer: Mr. Conway A. Ashton, President, Beneficial Life Ins. Co., 47 West South Temple, Salt Lake City, Utah 84101.

"B" agencies

Mr. Willard West, Director, Weber Basin Health Planning Council, 2570 Grant Avenue, Ogden, Utah 84401. Representative: Mr. Jack Oda, Clearfield, Davis County, Utah.

Mr. James L. Dallas, Executive Director, Great Salt Lake Health Planning Council, Suite 108, County Complex, 2033 South State Street, Salt Lake City, Utah 84115. Representative: Mr. Chuck M. Hardin, Equitable Life Ins. Co., 445 East 2nd South, Suite 310, Salt Lake City, Utah 84111.

VERMONT

"A" agency

Mr. David A. Miller, Director, Comprehensive Health Planning Agency, Central Planning Office, 114 Main Street, Montpelier, Vermont 05602. Consumer: Mr. W. James Preble, National Life Ins. Co., Montpelier, Vermont 05602.

"B" agencies

Mr. Eigil de Neergaard, Executive Director, Connecticut Valley Health Compact, Bank Block, Main Street, Springfield, Vermont 05156. Representative: Mr. Royal B. Holmes, Provident Mutual Life Ins. Co., Alstead, New Hampshire 03602.

VIRGINIA

"A" agency

Mr. Edward Springborn, Director, Office of Comprehensive Health Planning, State Dept. of Health, 109 Governor Street, Richmond, Virginia 23219. Representative: Mr. Harley Duane, Life Insurance Company of Virginia.

"B" agencies

Mr. Albert Castano, Health Planner, Peninsula Planning District Commission, Hampton, Virginia. Representative: Mr. Thomas G. Waters, C. B. West & Co.

Mr. Paul M. Morrison, Executive Director, Central Virginia Health Services Development Council, Inc., P.O. Box 1299, Lynchburg, Virginia 24505. Representative: None.

Mr. J. Joseph Moore, Executive Director, Tidewater Regional Health Planning Council, #5 Tidewater Executive Center, Suite 104, Norfolk, Virginia 23502. Representative: Mr. Sidney Kellam, Kellam-Eaton Ins. Co.

Mr. Robert J. Rollins, Executive Director, Capital Area Comprehensive Health Planning Council Inc., 3339 W. Cary Street, Richmond, Virginia 23221. Representatives: Mr. Howard McCue, Life Ins. Co. of Virginia; Mr. H. H. Southall, Southern Aide Life Ins. Co.; Mr. Jack Wilson, Waller-Stein Ins. Agency.

Mr. Frank H. Mays, Executive Director, Roanoke Valley Regional Health Services Planning Council, Inc., Box 2721, 621 Shenandoah Bldg., Roanoke, Virginia 24001. Representatives: Mr. Carl M. Andrews, President, Goodwin-Andrews-Bryan, Ins. Co.; Mr. T. T. Moore, Shenandoah Life Ins. Co.

New River Valley Planning District Comm., 1612 Wadsworth Street, Radford, Virginia 24141. Representative: Mr. W. E. McCoy, Jr., McCoy-Mensch Ins. Co.

Mr. Russell U. Owens, Executive Director, Appalachian Health Services Inc., State Health Dept., P.O. Box 1066, Wise, Virginia 24293. Representatives: Mr. Gene Orr, Peoples Life Ins. Co.; Mr. Haskell Arrington, Nationwide Ins. Co.

WASHINGTON

"A" agency

Mr. Frank D. Baker, Administrator, State Comprehensive Health Planning, Planning & Community Affairs Agency, Office of the Governor, 1306 Capitol Way, Olympia, Washington 98501. Representatives: Mr. Jack Ingram, New York Life, Box 99, Richland, Washington 99352; Mr. John A. E. Naess, Jr., Asst. V.P., Northern Life Tower, Seattle, Washington 98101.

WEST VIRGINIA

"A" agency

Mr. Harry A. Stansbury, Jr., Ph. D., Office of the Governor, 1712 McClung St., Charleston, West Virginia 25311. Representative: None.

WISCONSIN

"A" agency

Mr. Vincent F. Otis, Acting Director, Bureau of Comprehensive Health Planning, 1 W. Wilson St., P.O. Box 309, Madison, Wisconsin 53701. Representative: Mr. T. A. Duckworth, St. Vice President and Secretary, Employers Ins. of Wausau, Box 150, Wausau, Wisconsin 54401.

"B" agencies

Mr. George Curray, Exc. Dir., Northeastern Wisconsin Health Planning Council, Inc., Rice Bldg.—828 Cherry St., Green Bay, Wisconsin 54301. Representative: None.

Mr. Eugene Molitor, Executive Director, Western Wisconsin Health Planning Organization, Inc., Box 379, La Crosse, Wisconsin 54601. Representative: Mr. Thomas R. Larkin, 815 S. 17th St. (Insurance), La Crosse, Wis. 54601.

Mr. Paul Fleer, Exec. Dir., Health Planning Council, Inc., 15 West Main Street, Rm. 214, Madison, Wisconsin 53703. Representatives: Mr. Richard Pire, Family Ins. Co., 45 S. Eau Claire Ave., Madison, Wis. 43705; Mr. Herbert Raether, Insurance Agent, 1200 Maple Avenue, Columbus, Wisconsin 53925.

Richard Dahlby, Executive Dir., West Central Wisconsin Health Planning Council Inc., 103 1st Avenue West, Menomonie, Wisconsin 54751. Representative: None.

Mr. Eugene Cox, Exec. Dir., Comprehensive Health Planning Agency of Southeastern Wis., 110 East Wisconsin Ave., Milwaukee, Wisconsin 53202. Representative: Mr. Robert B. Barrows, Northwestern Mutual Ins. Co., Milwaukee, Wisconsin.

Mr. Val Chilsen, Pres., North Central Area Health Planning Assn., 1604 E. Main St., Merrill, Wisc. 54452. Representative: None.

WYOMING

"A" agency

Mr. Wayne LeBaron, Dir., Comprehensive Health Planning, Division of Health & Medical Services, Wyoming Dept. of Health & Social Services, Cheyenne, Wyoming 82001. Representative: None.

Personal Health Services Estimates For 1974 in Billions of Dollars

\$42	OUT OF POCKET	\$23	OUT OF POCKET
\$22	PRIVATE HEALTH INSURANCE	\$34	PRIVATE HEALTH INSURANCE
\$21	PUBLIC	\$28	PUBLIC
\$15	V.A., D.O.D. & OTHER UNAFFECTED PROG.	\$15	V.A., D.O.D. & OTHER UNAFFECTED PROG.

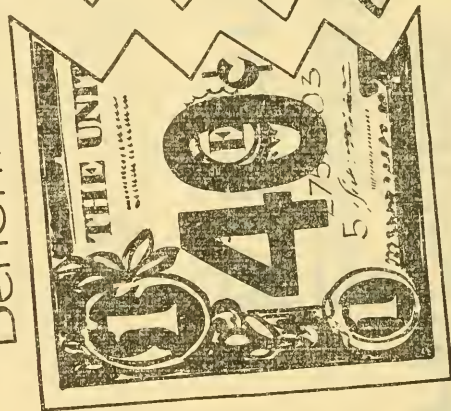
Present System H.I.A.A. Program
(H.R. 4349)

Source: H.E.W.

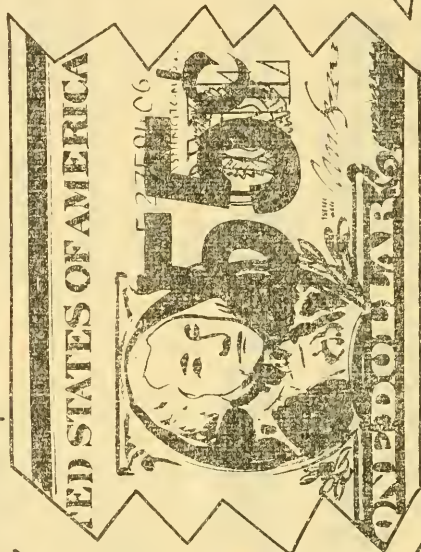
Source: Page 98, Analysis of Health Insurance Proposals: Ways & Means Comm. Aug. 1971

Individual Disability Income Premium Dollar Combined Insurance Group

Benefits



Administrative
Expenses & Profits



Taxes



Source: Combined Insurance Company of America:
Based on 1971 data

[Excerpts from "Group Insurance Manual"—John Hancock Mutual Life Insurance Co.]

UNDERWRITING RULES

Preface

HOME OFFICE APPROVAL

Home Office approval is required before submitting a quotation in the case of—

1. requests to write plans which are contrary to our standard underwriting practices as described herein,
2. requests to write any risks of a questionable nature,
3. requests for any changes under policies already in force with us,
4. requests to write coverage or coverages already in force with another group insurance carrier (for exceptions see page 5—Transferred Business).

(In all instances insurance can be bound only by the home office)

The general Underwriting Rules set forth in this section apply to all coverages except where specifically stated to the contrary.

It should be noted that separate sections of this Manual deal with the following subjects and reference should be made to these sections concerning applicable Underwriting Rules:

- Paid-Up
- Creditor
- Employee Life
- Canada
- 10-24 Plans
- Group Annuity
- Health Insurance Package

Information regarding the underwriting of the following coverages should be obtained from various notices from the Home Office dealing with these particular subjects:

- Medical Society Sponsored Plans
- Compulsory Disability Insurance
- Group Permanent Insurance
- Over Age 65 State Plans
- Voluntary Accidental Death & Dismemberment
- Long Term Disability

ELIGIBLE GROUPS

1. Sole Proprietorships
2. Partnerships
3. Corporations including
 - (a) Parent Corporation
 - (b) Affiliates and subsidiaries when controlled by the parent corporation. (It is difficult in some instances to determine whether or not proper control exists so that more than one company may be covered under a single group policy. Complete information must be obtained concerning stock ownership or other control which might establish the necessary legal relationship).
- *4. Labor Unions
- *5. Trustees of a fund established by
 - (a) One or more Labor Unions
 - (b) A single employer
 - (c) Two or more employers in the same industry
 - (d) Employer-members of a Trade Association
 - (e) One or more employers and one or more Labor Unions.

*6. Employees of political subdivisions (cities, towns, government agencies, etc.)

Although the above classifications are generally satisfactory groups, individual cases falling in these classifications may have characteristics which make them undesirable from an underwriting viewpoint.

*These classifications are subject to a wide variety of legal, underwriting, and administrative complexities which require specialized consideration. Home Office approval must be obtained prior to any quotation on these classifications in order that specific instructions may be given as to the information which will be needed for sound underwriting of the risk.

INELIGIBLE GROUPS

1. Lodges and Clubs
2. Fraternal Societies
3. Groups lacking cohesion
4. Groups currently insured for the applicable coverage in another company where the intent is to continue the coverage with both companies. (Except that upon reference to the Home Office certain select groups may be considered for additional amounts of Life insurance.)
5. Employee Associations

CASES TO BE REFERRED TO HOME OFFICE

If any of the following factors are present in an otherwise eligible group, the case should be referred to the Home Office for consideration.

1. There is a large number of unskilled employees whose working and living conditions and allied factors are unfavorable.
2. Employment is unstable.
3. A large proportion of the employees are receiving minimum wages.
4. There is any question as to lack of control by stock, contract or otherwise.
5. The industrial hazard is great and the industrial classification is undetermined or unknown.
6. Coverage is desired on pensioned or retired employees.

In addition to the above factors the following factors apply to the coverages specified:

Accidental Death and Dismemberment

1. Group Life insurance is not already in force and is not being added concurrently.
2. Certain hazardous groups may be offered non-occupational benefits in lieu of twenty-four hour coverage.

Accident and Sickness, Hospital Expense, Surgical Expense and Medical Expense Coverages

1. Group Life insurance is not already in force and is not being written concurrently.
2. The group contains more than 50% of married females.
3. 31% or more of the insurance is on eligible unskilled employees, (41% or more for Hospital, Surgical, and In-Hospital).
4. Where Group coverages are not to be combined for financial experience.
5. Salaries or wages are continued during disability (A&S only).
6. There are 15% or more of the employees at ages 60 and above or 5% ages 70 and above (A&S and Medical only).

SIZE AND ENROLLMENT REQUIREMENTS

Employee Coverages

A minimum of 25 insured lives.

1. If the number of insured employees is 50 or more, at least 75% enrollment of the eligible employees must be obtained.

2. If the number of insured employees is less than 50, at least 85% enrollment of the eligible employees must be obtained, with a minimum of 25 lives insured.

In addition to the requirements listed above the following requirements apply to the coverages specified:

Accident and Sickness

13 or 26-week plans—A minimum of 25 insured lives.

Except a minimum of 4 insured lives may be written for the statutory coverage issued to conform with the New York Disability Benefits Law.

52-week plans—A minimum of 50 insured lives.

Dependent Coverages

A minimum of 10 employees insured for dependent coverage.

1. If the number of insured employees is 50 or more, at least 75% enrollment of the eligible employees with dependents must be obtained with a minimum of 10 employees insured for dependent coverage.

2. If the number of insured employees is less than 50, at least 85% enrollment of the eligible employees with dependents must be obtained with a minimum of 10 employees insured for dependent coverage.

MINIMUM COVERAGE COMBINATION REQUIREMENTS

Group Life insurance for employees may be written alone.

Group Life insurance for dependents and Accident & Health coverages for employees and dependents will be written only where the John Hancock already has Group Life insurance coverage on the employees, or it is being written concurrently, except where specific Home Office approval is obtained. Where permitted by law, all coverages for a new policyholder will be written in a single policy.

The following minimum coverage combination requirements are applicable to the particular coverages specified and are in addition to the general requirement that there is Group Life insurance on the employees with the John Hancock.

Hospital Expense.—The 365 day plan is written only in conjunction with Major Medical Expense.

Surgical Expense.—This coverage is written only in conjunction with Accident and Sickness or with Hospital Expense or with Life insurance.

Major Medical.—Supplementary Major Medical is written only to supplement a John Hancock or Blue Cross-Blue Shield base coverage.

Medical Expense Coverages.—

Medical Expense Coverages.—

1. Medical Expense (Plan C), or Comprehensive Medical Expense (Plan E), is written only in conjunction with Accident and Sickness plus Surgical Expense or with Hospital Expense plus Surgical Expense.

2. In-Hospital Medical Expense (Plan G) is written only in conjunction with Hospital Expense plus Surgical Expense. (The maximum period for the Medical Expense plan can be no greater than the duration of the Hospital Expense plan.)

3. Laboratory and X-Ray Examination Expense (Plan H), or X-Ray Examination Expense (Plan I), are written only in conjunction with Hospital Expense.

4. Supplemental Accident Expense \$500 Maximum (Plan J) is written only in conjunction with all of the following coverages:

(a) Hospital Expense—at least \$12.00 Maximum Daily Benefit, 31 days coverage, and 10 times for Special Services.

(b) Surgical Expense—at least \$300 Maximum.

(c) Medical Expense—In-Hospital Medical Expense with benefits of at least \$3.00.

5. Poliomyelitis Expense (Plan K) is written in conjunction with Hospital Expense.

Dependent Hospital Expense.—This coverage is written only in conjunction with Employee Hospital Expense.

Dependent Surgical Expense.—This coverage is written only in conjunction with Employee Surgical Expense.

Dependent Major Medical Expense.—This coverage is written only in conjunction with Employee Major Medical Expense.

Dependent Medical Expense Coverages

1. Dependent Comprehensive Medical Expense (Plan E) or Dependent In-Hospital Medical Expense (Plan G) are written only in conjunction with all of the following coverages:

(a) Employee Hospital Expense

(b) Employee Surgical Expense

(c) Dependent Hospital Expense

(d) Dependent Surgical Expense

(e) Employee Medical Expense

2. Dependent Laboratory and X-Ray Examination Expense (Plan H) and Dependent X-Ray Examination Expense (Plan I) are written only in conjunction with all of the following coverages:

(a) Employee Hospital Expense

(b) Dependent Hospital Expense

(c) Employee Medical Expense—Laboratory and X-Ray Examination Expense (Plan H) or X-Ray Examination Expense (Plan I).

3. Dependent Supplemental Accident Expense (Plan J) with a \$300 Maximum is written only in conjunction with all of the following coverages:

(a) Employee Supplemental Accident Expense and its prerequisite coverages

- (b) Dependent Hospital Expense—at least \$12.00 Daily Benefit or Maximum Daily Benefit, 31 days coverage, and 10 times for Special Services
 (c) Dependent Surgical Expense—at least \$300 Maximum
 (d) Dependent Medical Expense—Dependent In-Hospital Medical Expense with benefits of at least \$3.00.

4. Dependent Poliomyelitis Expense (Plan K) is written only in conjunction with all of the following coverages:

- (a) Employee Hospital Expense
 (b) Dependent Hospital Expense
 (c) Employee Poliomyelitis Expense.

Where Dependent coverages are written, the Employee coverages generally must be as liberal as the Dependent coverages.

MINIMUM AND MAXIMUM AMOUNTS OF INSURANCE

Group Life Insurance on Employee (Normal Maximums)

1. The minimum amount of insurance issued for an employee in any class is \$1,000.

2. The normal maximum amount of insurance issued for an employee in any class is determined by the following table. Rules for providing maximums in excess of the normal maximums shown below are outlined on the next page under the heading "Excess Group Life Insurance."

Total insurance in group when actually issued		Maximum amount if the average amount per employee is				
At least—	but less than—	Less than \$4,000	\$4,000 but less than \$6,000	\$6,000 but less than \$8,000	\$8,000 but less than \$10,000	\$10,000 and over
	\$100,000	\$10,000	\$11,000	\$12,000	\$13,000	\$14,000
\$100,000	200,000	12,000	13,000	14,000	15,000	16,000
200,000	300,000	14,000	15,000	16,000	17,000	18,000
300,000	400,000	16,000	17,000	18,000	19,000	20,000
400,000	500,000	18,000	19,000	20,000	21,000	22,000
500,000	600,000	20,000	21,000	22,000	23,000	24,000
600,000	700,000	22,000	23,000	24,000	25,000	26,000
700,000	800,000	24,000	25,000	26,000	27,000	28,000
800,000	900,000	25,000	26,000	27,000	28,000	29,000
900,000	1,100,000	26,000	27,000	28,000	29,000	30,000
1,100,000	1,130,000	27,000	28,000	29,000	30,000	31,000
1,300,000	1,500,000	28,000	29,000	30,000	31,000	32,000
1,500,000	1,700,000	29,000	30,000	31,000	32,000	33,000
1,700,000	1,900,000	30,000	31,000	32,000	33,000	34,000
1,900,000	2,200,000	31,000	32,000	33,000	34,000	35,000
2,200,000	2,500,000	32,000	33,000	34,000	35,000	36,000
2,500,000	2,800,000	33,000	34,000	35,000	36,000	37,000
2,800,000	3,200,000	34,000	35,000	36,000	37,000	38,000
3,200,000	3,600,000	35,000	36,000	37,000	38,000	39,000
3,600,000	4,000,000	36,000	37,000	38,000	39,000	40,000
4,000,000	4,500,000	37,000	38,000	39,000	40,000	41,000
4,500,000	5,000,000	38,000	39,000	40,000	41,000	42,000
5,000,000	5,500,000	39,000	40,000	41,000	42,000	43,000
5,500,000	6,000,000	40,000	41,000	42,000	43,000	44,000
6,000,000	6,500,000	41,000	42,000	43,000	44,000	45,000
6,500,000	7,000,000	42,000	43,000	44,000	45,000	46,000
7,000,000	7,500,000	43,000	44,000	45,000	46,000	47,000
7,500,000	8,000,000	44,000	45,000	46,000	47,000	48,000
8,000,000	8,500,000	45,000	46,000	47,000	48,000	49,000
8,500,000	9,000,000	46,000	47,000	48,000	49,000	50,000
9,000,000	9,500,000	47,000	48,000	49,000	50,000	50,000
9,500,000	10,000,000	48,000	49,000	50,000	50,000	50,000
10,000,000	10,500,000	49,000	50,000	50,000	50,000	50,000
10,500,000 and over	-----	50,000	50,000	50,000	50,000	50,000

Rules for the use of the above schedule of maximums are continued on the next page.

PREMIUM RATES

LOADINGS

Extra premiums may be required on certain plans of insurance when the characteristics of the group differ from a standard group. Such extra premiums or loadings are determined separately for each of the conditions.

Industry Loadings.—For insurance other than Major Medical insurance see the Industry Loadings table. Any case involving Major Medical insurance for one of the listed industries should be referred to the Home Office.

Old Age Loadings.—For Accident and Sickness insurance, a loading may be required if 15% or more of the insurance on all eligible employees is in force on eligible employees over age 60 or if 5% or more of the insurance on all eligible employees would be on eligible employees age 70 and over. Such cases should be referred to the Home Office.

Married Female Loadings.—A loading may be required on insurance other than life insurance if 50% or more of the employees are married females. Such cases should be referred to the Home Office.

Environment Loadings.—A large part of the higher mortality and morbidity experienced by certain groups results from working and living conditions of the employees in the group. The fact that a large percentage of the insurance is to be on unskilled workers or non-Caucasian employees may be an indication that such conditions exist. All cases where insurance on eligible unskilled or non-Caucasian employees is 31% or more of the insurance on all eligible employees (41% for Hospital Expense, Surgical Expense, Medical Expense and Major Medical Expense insurance) should be referred to the Home Office.

In determining the amount of insurance on any portion of all eligible employees or on all eligible employees in a group, use the following units of insurance for the coverages indicated:

Life, and Accidental Death and Dismemberment insurance.—Use the amount of insurance payable in the event of death of each employee.

Accident and Sickness insurance.—Use the amount of insurance payable weekly to each employee.

Hospital Expense insurance.—Use the amount of maximum daily benefit applicable to each employee.

In-Hospital Medical Expense insurance.—Use the amount of daily Medical Expense benefit applicable to each employee.

Medical Expense insurance, and Comprehensive Medical Expense insurance.—Use the amount of maximum reimbursement for an office treatment applicable to each employee.

Surgical Expense insurance, Laboratory and X-Ray Examination Expense, and X-Ray Examination Expense insurance.—Use the overall maximum reimbursement applicable to each employee.

Major Medical Expense insurance.—Use the amount of the aggregate lifetime maximum benefit applicable to each employee.

INDUSTRY LOADINGS

Extra premiums may be required for certain industries either because of health hazards or because of the hazardous nature of the industry, or both. The Company reserves the right to charge a higher extra premium than stated below or charge an extra premium in the case of an industry not listed below.

The case should be referred to the Home Office for rating if there is any doubt the appropriate rate or if the risk involves two or more industries for one or more of which extra premium is required. Distribution of employees in each industry by occupation and amounts of insurance should be supplied.

The extra premiums shown below for Life Insurance are the minimum first year extra premium rates per \$1,000 of insurance. The extra percentages shown below for Accident and Sickness, Medical Expense and Hospital Expense should be applied to the base rate or to the base rate plus other loadings, if any. The industry loadings shown below are not required for Employee Surgical Expense, Poliomyelitis Expense, Supplemental Accident Expense or any Dependent Coverages.

List of industries	Extra Premiums or Loadings	
	Life	Accident and sickness, hospital expense, medical expense
Aviation schools:		
If flying personnel excluded from coverage.....	None.....	None.
If flying personnel included and is under Civil Aeronautic Board regulations.....	\$3 on flying personnel.* None for other personnel. ¹	Do.
Chemical and allied industries:		
Acids (heavy) manufacture of: carbolic, hydrochloric, hydrofluoric nitric, prussic, sulphuric sulfurous, etc.....	\$2.....	Do.
Gases (poisonous and corrosive) manufacture of.....	\$2.....	Do.
Explosive and fireworks, manufacture of.....	\$3.....	Do.
Fertilizer.....	\$2.....	Do.

Footnotes at end of table.

List of industries	Extra Premiums or Loadings	
	Life	Accident and sickness, hospital expense, medical expense
Construction:		
Bridge.....	\$1	Do.
Dam.....		
Road.....		
Sewer.....		
Structural iron and steel buildings.....		
Hot metal industries:		
Foundries.....	None	15 percent note: If the basic industry is other than a foundry but foundry operations are involved, a composite loading is required. Employees in the occupations commonly designated as follows should be considered as foundry employee in determining the composite loading. ²
Malleable iron works.....		
Rolling mills.....		
Steel works.....		
Smelting and refining.....		
Tube.....		
Rod and pipe mills.....		
Wire drawing.....		
Iron and steel: Iron ore milling and blast furnace operation (risks engaged in steel making even though including blast furnaces may be written without an extra premium rate).	\$1	None.
Iron and steel foundries (if the basic industry of a risk is other than a foundry but foundry operations are involved, a composite extra premium will be determined).	\$1	15 percent.
Lumber: Loggers or woodsmen.....	\$3 ³	25 percent if operation starts with the tree or the log.
Marble and stone yards and mills.....	\$3	15 percent. ⁴
Mining (surface and underground).....	\$3	Refer to home office. ⁵
Miscellaneous:		
Alcohol distilleries (ethyl, methyl, or alcoholic beverages).....	None	15 percent.
Asbestos milling, and manufacture of cord and fabric.....	\$2	None.
Breweries.....	Refer to home office.	Refer to home office.
Cement (no quarrying).....	None	15 percent.
Fire departments.....	\$3	None.
Fishing (deep sea).....	\$5	Do.
Furriers.....	None	15 percent.
Gypsum (no quarrying).....	do	15 percent.
Hat factories:		
Fur felt (regardless of carotting).....	do	Refer to home office.
Wool felt.....	do	25 percent.
Lime (no quarrying).....	do	15 percent.
Police departments.....	\$3	None.
Rockwool manufacture.....	\$2	Do.
Tanneries.....	None	15 percent. ⁶
Wine, manufacturers and merchants.....	do	15 percent.
Quarrying (any substance including rock minerals such as clay, feldspar, phosphate, salt shale, talc, etc.)	\$3	Refer to home office.
Refractories (manufacturing firebrick or fire-resistant materials composed chiefly of silica or silicate materials).	\$2	15 percent.
Smelting and refining of metals:		
By electrolytic process.....	None	None.
By other than electrolytic process.....	\$1	See hot metal industries.
Textiles (includes any and all operations from the receipt of the raw materials to and including spinning, weaving, knitting, braiding, bleaching, dyeing and finishing of any product from cotton, wool, rayon, hemp, jute, silk, and linen).	None	Refer to home office.
Transportation:		
Air transport companies:		
If flying personnel is excluded from coverage.....	do	None.
If flying personnel included and is under Civil Aeronautic Board regulations and flights are over the regular routes including transoceanic.....	\$3 on flying personnel, no extra on other personnel. ⁷	Do.
Electric and street railroads (other than subways and elevated railroads.)	\$1	25 percent.
Subways and elevateds.....	\$3	25 percent.
Steam railroads (class I railroads).....	\$1	25 percent.
Terminal railroads and other railroads not class I railroads.....	\$3	25 percent.
Stevedoring, lightering, tugs, barges, and dredges.....	\$2	None.

¹ Extra is charged separately not as a composite premium rate.

² Coremakers, melters, moulders, cupola tenders and their helpers, foundrymen, and foundry foremen. Foundry helpers and laborers, including among others coal and coke heavers, ladlers, pig breakers, and sand shovellers. Casting cleaners including among others grinders, sand blasters, chippers, rattlers, and snagers.

³ Since this classification specifically refers to occupations, a composite extra premium rate will be obtained, charging \$3 extra for insurance on employees in the woods with no extra premium for insurance on sawmill workers—if an employee works both as a sawmill worker and as a logger or a woodsman, he is considered as a logger or woodsman for the purposes of determining the composite extra premium rate.

⁴ A higher percentage may be required if cutting and polishing operations are an important part of the work.

⁵ Specially selected risks engaged in gold mining may be written at a \$1 minimum.

⁶ Specially selected risks may be considered by the home office at lower loading on Hospital Expense.

* ⁷ Extra charged separately not as a composite premium rate.

GROUP POLICY—CONVERSION RIGHTS

CONVERSION PRIVILEGE—GROUP LIFE INSURANCE

General

If a person has been insured for Group Life Insurance, and if he terminates his employment, he may convert his Group Insurance to an Ordinary policy without medical examination within 31 days of termination of employment upon payment of the premium for the Ordinary policy. A substantially similar right of conversion is provided by the Group policies upon termination of an employee's coverage under certain other circumstances (see your Specimen Policy). The Ordinary policy will be in any one of the forms customarily issued by the Company at the date of conversion with the exception that it shall not be a policy of Term Insurance nor shall it contain provisions for disability or other supplementary benefits; however, Group Policies being issued in the states of New York and West Virginia must provide that the Ordinary policy may be preceded by Term Insurance for up to a maximum of one year.

If asked to assist in handling a conversion for an employee, the first and most important step is to read carefully the Conversion Privilege printed in the employee's own Group certificate and determine the maximum amount of insurance that may be converted to the Ordinary basis. If the Group certificate is for an amount less than \$1000 the insurance may be converted even though the Company does not normally issue an Ordinary policy for less than \$1000.

The employee's certificate will also indicate when Group coverage ceases. The issue date of the Ordinary policy will be the 32nd day following termination of employment unless, to avoid a higher ratable age, the policy is issued on the 32nd day but dated back to secure the premium for the lower age. In some states failure to give notice of a conversion right extends the conversion period. No Ordinary policy converted from Group insurance will be given a date of issue later than the 32nd day following the date of termination of employment (except under the unusual condition of failure to give notice).

When termination of employment is the reason giving rise to the conversion, it is important that the date of termination of employment be accurately determined. The former employee's last working day is not necessarily the official date of termination of employment as shown on the employer's records or for insurance purposes. Therefore, an effort should be made to try to find out the effective date of termination according to the former employer's records and terms of the Group Policy.

Premium rates for the new Ordinary policy will be based on the ratable age of the applicant on the date of its issue and on the plan and amount of insurance selected. The premium will be that applicable to the class of risk to which the applicant belongs considering age, occupational hazards and possibilities of foreign travel or residence.

The Group conversion application is Form 128-0-55. In order to assure continuous insurance coverage, the first premium should be collected with the application for conversion and a receipt given for the payment. The completed application and the Group certificate should be submitted together for processing. If the certificate has been lost, the applicant should sign a brief statement showing the Group certificate and Group policy number and explain how the certificate was lost or destroyed. This statement should then accompany the Group conversion application form in lieu of the certificate.

Employees of Federal Government

A Federal civilian employee who is leaving Government service has a conversion privilege slightly different from that customarily included in Group contracts since he will have a choice of a large number of insurance companies (including the John Hancock) for selection of a converted policy. The conversion procedure is somewhat simplified since it is unnecessary for the agent to check the provisions of the Group policy or certificate. The employee need not surrender his certificate. He is, however, obliged to furnish the Company with a special form letter from the Office of Federal Employees' Group Life Insurance specifying his conversion rights. This letter must accompany the conversion application; otherwise the application cannot be considered.

The form letter, referred to in the preceding paragraph, is obtained in the following manner. The employee will have been given a "Notice of Conversion Privilege," standard Form No. 55 of the Government, by his employing agency. If he desires to exercise his conversion privilege, he will then obtain from his employing agency a Government form "Agency Certification of Insurance Status,"

standard Form No. 56. The employee will follow the instructions on this latter form which direct him to send the original of this form to the Office of Federal Employees' Group Life Insurance who will then write the employee a letter stating specifically the "Last Day of Life Insurance Protection Under the Group Policy," the "Maximum Insurance That May Be Converted" and the "Date Conversion Right Expires" as well as supplying him with a list of insurance companies through which he may arrange for the conversion of his Group Life insurance to an individual policy.

In the case of such a Federal civilian employee who is leaving Government service, the date of issue of the converted policy usually will be the day following the "Last Day of Life Insurance Protection Under Group Policy" as shown in the letter. However, where the "Date Conversion Right Expires" is later (as the result of an extension of the conversion period), the date of issue may be any time up to such later date.

Dependents Conversion Privilege

When Dependent Life insurance is provided under the Group Policy, a conversion right is made available to the spouse, and where required by law, to any covered children. This conversion right for the dependent arises when the employee also has a right to convert.

Something more than half of the jurisdictions permit the writing of Dependent Group Life insurance, and the list changes from time to time; the permitted schedules and the conversion rights also vary among states. The agent or Group representative should determine the applicable requirements of the jurisdictions in his area. The Home Office will be glad to furnish the information for individual states upon request.

Procedure for Regular Application

A regular application for Ordinary insurance is taken when this procedure is acceptable to the applicant. When this regular application is made within the conversion period, a Group conversion application should also be completed, even though it is to be acted upon only in the event that the regular application is not approved as applied for. The Ordinary Reference Manual contains instructions as to the proper notations to be entered on the two applications so that they may be submitted together and only one acted upon by the Company. By following the procedure outlined in that reference manual, the agent can be sure that the Company will act first on the regular application and that, if such application cannot be approved as applied for, the Company will then proceed to convert the Group certificate.

Types of Ordinary Policies

The Company now issues Ordinary policies in two series :

Amount \$5,000 and under—Multiple Protection series

Amount \$5,000 or over—Select series

Although Multiple Protection policies usually include, for issue ages below 56, a disability waiver of premiums benefit and a benefit for loss of Hands, Feet or Sight, and an accidental death benefit for issue ages below 66, these benefits will not be included automatically in any policy issued upon conversion of Group insurance. On either Select or Multiple Protection policies, the applicant may add additional benefits by applying for them in the normal manner. The premium rate charged will be the same as that for identical benefits at the same issue age under an Ordinary policy applied for in the usual manner.

Within these limitations and below age 75, an individual may apply for any plan of individual insurance listed in the Ordinary rate manual except term insurance, subject to any applicable plan amount minimums.

Plans available to applicants over age 75 are Single Payment Life (for issue ages 76-85) and 10 Year Payment Life (for issue ages 76-90).

When conversion in an amount of \$5000 and under is applied for through a District Office, the applicant has the option of applying for a Monthly Debit Ordinary policy if he prefers to pay premiums monthly to an agent.

CONVERSION PRIVILEGE—GROUP ACCIDENT AND HEALTH INSURANCE

The Conversion Program, as outlined herein, is available to Eligible Group Policyholders and Eligible Applicants in the District of Columbia and all states except California and New York. Programs for California and New York require certain modifications, and the available plans and rates have been furnished to

Home Office Representatives working in those areas. At the present time, we do not intend to have a Conversion Program available in Canada or Puerto Rico.

General

Subject to underwriting rules, a Conversion Privilege may be added, by amendment, to Group Accident and Health coverages other than Group Accidental Death and Dismemberment and Group Accident and Sickness coverages.

This Privilege will permit individuals, whose Accident and Health Insurance under the Group Policy terminates because of certain specific reasons, to apply for and have issued, without evidence of insurability, a non-group Personal Health Insurance policy insuring themselves and, if desired, their dependents whose Group Accident and Health Insurance also terminates.

The Converted Policy will be known as a "Personal Health Policy—Group Conversion," and will be renewable on any premium due date at the option of the Company. The type of coverage and amount of benefits available for an individual converting from a specific Group Policy will be controlled by the Group Policyholder's and the individual's selection of coverage and benefits in accordance with applicable underwriting rules. Terms of coverage and benefits may be determined from the sample standard policy form (Form PII-030-61) included elsewhere in this section of the manual. Attention is directed to the fact that certain of the benefits provided are different for individuals converting at age 65 or over or who reach age 65 after conversion, than are provided for those under age 65. Also, that Maternity coverage, if elected by the Group Policyholder, provides benefits only when husband and wife are both insured under the same Converted Policy.

Where required by state insurance laws, certain endorsements will be attached to the standard Converted Policy form. These modifications, however, do not affect the general type of coverage or benefits of the policy.

The "Personal Health Policy" may be applied for only within 31 days of the date of termination of Group Accident and Health Insurance. In order to avoid having any period without coverage, such policies will always become effective on the date following the date of termination of the individual's Group Insurance. Policies may be issued on a quarterly, semi-annual, or annual basis. Sample policies, application forms, and premium tables with calculation instructions, will be available to Applicants at the Policyholder's office and detailed instructions to the Policyholder for the administration of this part of his Group Program will be included in the Group Administration and Claims Manual furnished to him. Policies will be issued at the Home Office and all services in connection with the policy will be rendered to the Applicant directly from the Home Office. An outline of procedure for application and policy issue is contained herein under the heading "Procedure for Application and Policy Issue."

Group Premium Rates

Although initial or in force Group rates will not be increased because of the addition of the Privilege, the Policyholder desiring to include it in his program should be informed:

1. That an expense charge will be made under the dividend formula to cover certain additional administrative expenses of the Group Department resulting from the inclusion of the Privilege and
2. That rates for the Converted Policies have been established at a level we feel to be self-sustaining and, that the experience of all Converted Policies arising from all Group Policies having the Privilege will be pooled. If, under the pooling arrangement, losses develop in excess of those expected, an additional charge may be made, through the dividend formula, to Policyholders having the Conversion Privilege.

UNDERWRITING RULES

Groups Eligible

The Company desires that this Conversion Privilege be offered only when a definite request for it originates with a Group Policyholder or Prospect who has a special need for it; who is willing to cooperate in its administration; and, who is willing to assume the additional cost involved. It will be available to Policyholders having at least twenty-five employees and may be offered to new "Single Employer" cases without prior Home Office approval. On cases that are in force, or that are to be insured on other than a "Single Employer" basis, we will require prior Home Office approval because of the necessity of considering current Group experience and the facilities of the Policyholder for the proper administration of the program.

Because of the high cost of Converted Policies at the older age levels, whenever the Privilege is requested, every effort should be made to have the Policyholder agree to continue Group Accident and Health Insurance on retiring employees (and their dependents) rather than having the Conversion Privilege apply to them. Where Group Insurance is to be continued on such employees, proposed benefits and applicable Group rates should be discussed with the Underwriting Division before final commitments are made.

It is suggested that a Group Policyholder, having the Conversion Privilege, continue Group Accident and Health Insurance on his employees (and their dependents) during any reasonable periods of temporary layoff rather than having a large number of Converted Policies issued for a short duration. The standard Group Policy permits this continuance to the end of the policy month next following the policy month in which the employee ceased active work. Where desired and in connection with the inclusion of the Conversion Privilege, the Company is willing to consider reasonable extensions of this period. The possibility of such an extension on any given case should be discussed with the Underwriting Division.

Individuals eligible to apply for or be covered under a "personal health policy—group conversion":

The following individuals are eligible for coverage under a Converted Policy upon termination of their Group Accident and Health Insurance provided they have been insured or covered under a Group Policy containing the Conversion Amendment: that such Group coverage is in force on, and does not terminate coincident with, the date the individual becomes eligible; that they are not otherwise eligible to be insured under the same Group coverage as employees or dependents; and, that application is made, and full first premium is paid, within 31 days of the date Group Insurance terminates.

A. Eligible to apply for and be covered under Converted Policy:

1. All employees, regardless of age, whose Group Insurance terminates because of:

i. termination of employment,

ii. transfer out of the class of employees eligible for such insurance.

2. An employee's spouse whose insurance under the dependent Group coverage terminates because of the death of the employee.

3. An employee's child whose insurance under the dependent Group coverage terminates because of reaching the maximum age under the Group dependent definition.

B. Eligible to be covered as dependents under Converted Policy:

1. Dependents, as defined in the Group Policy, of employees or of an employee's spouse outlined in 1 and 2 above. (Provision is made under the terms of the Converted Policy itself for the subsequent addition of certain dependents after the policy is issued—see General Provision 1 of the Converted Policy.)

Coverage or combination of coverages available for a group policyholder's selection under a conversion program; and conditions pertaining to such selection:

Subject to the Group Policyholder's selection in accordance with the conditions outlined below, the following coverage or combination of coverages are available under a Conversion Program:

A. Hospital Expense Insurance.

B. Hospital Expense and Physicians In-Hospital Medical Expense Insurance.

C. Hospital Expense and Surgical Expense Insurance.

D. Hospital Expense, Surgical Expense, and Physicians In-Hospital Medical Expense Insurance.

All of which exclude coverage for pregnancy. When the Group Policy, from which the Conversion Program arises provides pregnancy coverage for dependent wives, a Maternity coverage is available with A, B, C, or D, above. This Maternity coverage will be included only in policies insuring husband and wife, and will be only for pregnancies commencing while husband and wife are insured under the Converted Policy.

The Group Policyholder will be permitted to select for inclusion in his Conversion Program any coverage or combination of coverages available provided similar coverage or combination of coverages is included under his Group Policy. If insurance on dependents is included in the Group Policy, a Group Policyholder electing a Conversion Program will be required to have it apply to eligible dependents as well as eligible employees. When the Conversion Program applies to dependents, the selected coverages must not exceed those that are included

for dependents under his Group Policy, and the coverages for employees and dependents must be the same. For this purpose:

(a) the In-Hospital Medical coverage would be available to any Group Policyholder having In-Hospital Medical, Disability Medical or Comprehensive Medical Expense coverage, or Major Medical Expense coverage on a Supplemental basis with a reasonable deductible, and

(b) a Group coverage of Major Medical Expense on a Comprehensive basis, with a reasonable deductible, and with or without underlying coverage, would be assumed to include all types of coverage available other than the Maternity coverage. If the Major Medical includes the special pregnancy coverage or if pregnancy coverage is included in the underlying coverages, the Maternity coverage of the Converted Policy may be selected.

Amounts of benefits available for a group policyholder's selection under a conversion program; and conditions pertaining to such selection:

Subject to the Group Policyholder's selection in accordance with the conditions outlined below, the following amounts of benefits are available under a Conversion Program:

A. For individuals converting under age 65 or for any insured individual prior to reaching age 65:

1. Hospital Expense Benefit:

i. Daily Hospital Benefit—A range from a minimum of \$6.00 to a maximum of \$15.00 (in full dollar units).

ii. Maximum Hospital Services Benefit—10 times the Daily Hospital Benefit.

iii. Maximum Hospital Expense Benefit Period—31 days.

2. Physicians In-Hospital Medical Expense Benefit:

i. Daily Medical Benefit—\$3.00.

ii. Maximum Medical Benefit—\$93.00.

3. Surgical Expense Benefit:

i. Maximum Surgical Expense Benefit (Schedule Maximum)—\$200 or \$300.

ii. Scheduled Benefits by type of operation—See attached specimen policy for schedule used with \$200 Maximum Benefit Plan. Schedule used with \$300 Maximum Benefit Plan is 50% higher for all operations.

4. Maternity Benefit:

i. Maximum Normal Maternity Benefit—10 times the Daily Hospital Benefit selected under the Hospital Expense coverage.

B. For individuals converting at age 65 or over, or for any insured individual upon reaching age 65.

i. Maximum Hospital Service Benefit is reduced from 10 times to 5 times the Daily Hospital Benefit

ii. Maximum Hospital Expense Benefit Period is reduced from 31 days to 21 days

iii. Maximum Medical Benefit is reduced from \$93.00 to \$63.00

The Group Policyholder must select all the amounts of benefits, including the range of Daily Hospital Benefits, that are available for the coverages he has included in his program, except

(a) the maximum amount of the range of Daily Hospital Benefit may never be in excess of the smallest like amount provided under the Group Policy for any individual but may be less than such amount if the Group Policyholder so elects, and

(b) only one Maximum Surgical Expense Benefit may be selected and this amount must always be \$200 unless all individuals covered under the Group Policy are insured for a like amount of \$300 or more, in which event the Group Policyholder may select either the \$200 or \$300 amount.

For this purpose, a Group coverage of Major Medical Expense on a Comprehensive basis, with a reasonable deductible, and with or without underlying coverage, would be assumed to include a maximum amount of Daily Hospital Benefit equal to the maximum private room allowance of the Major Medical plan and a Maximum Surgical Expense Benefit of \$300. When the Conversion Program applies to dependents, the selected amounts for employees and dependents must be the same.

Coverage or combination of coverages available to the applicant under a "personal health policy—group conversion" and conditions pertaining to the applicant's selection of coverages:

The coverages available for an Applicant and, if eligible, his dependents, are those selected by the Group Policyholder excluding any such coverage for which

the employee, or his dependents who were insured under the Group Policy, were not covered. An Applicant must apply for the coverage or combination of coverages available to him except, when the Conversion Privilege applies to dependents, the Applicant may apply for a Converted Policy for:

(a) Himself only, or

(b) Himself and his eligible dependents. If he does apply for his eligible dependents, he must include all his eligible dependents except, he may omit dependents who are in the armed forces. He may not include any dependent who was not insured under the Group Policy as a dependent. (Provision is made under the terms of the Converted Policy for the subsequent addition of certain dependents after the policy is issued—see General Provision 1 of the Converted Policy.)

Amounts of benefits available to the applicant under a "personal health policy—group conversion" and conditions pertaining to the applicant's selection of amounts of benefits:

The amounts of benefits available for an Applicant and, if eligible, his dependents are those selected by the Group Policyholder. An Applicant must apply for the amounts of benefits available to him except, he may apply for only one amount of Hospital Expense—Daily Hospital Benefit, and that amount may be equal to or less than the maximum amount selected by the Group Policyholder but such amount must be a full dollar unit, not less than \$6.00, and the same for all persons to be insured under the policy.

PROCEDURE FOR APPLICATION AND POLICY ISSUE

A sample application form is included elsewhere in this section of the manual.

Applications will be secured by the Applicant from the Group Policyholder who, by first completing Part A of the form, will furnish to the Applicant and to the John Hancock data necessary to determine coverages and benefits available, and eligibility.

Part B of the application is completed by the Applicant. Although specific instructions are contained on the reverse side of the application, it is suggested that, whenever possible, the application be completed in the office of the Policyholder and that the Policyholder render the Application any assistance he may require. Copies of premium tables with calculation instructions will be furnished to the Policyholder for mailing with the application to any Applicant who finds it inconvenient to come to the office or who may otherwise desire them.

Completed applications together with check for the full first premium are to be mailed directly to the Group Records Division at the Home Office. After verification, they are referred to the Personal Health Division for the issuance of a Converted Policy. Where a Resident Licensed Agent's counter signature is required, policies will be sent to properly licensed Group Home Office Representatives who, after signing them, will return them to the Home Office.

The following States require countersignature by a Resident Licensed Agent in the space provided on the filing back of the policy form.

STATES

Alabama	Michigan	South Carolina
Colorado	Mississippi	Utah
Connecticut	New Mexico	Vermont
Georgia	New York	Virginia
Hawaii	North Carolina	West Virginia
Idaho	North Dakota	Wisconsin
Illinois	Ohio	Wyoming
Kansas	Oregon	
Maine	Rhode Island	

PREMIUM RATES FOR "PERSONAL HEALTH POLICY—GROUP CONVERSION"

A "Personal Health Policy—Group Conversion" may be issued on a quarterly, semi-annual, or annual basis. Applicable premium rate tables, by coverage, are included elsewhere in this section of the manual.

Premium rates for adults are based on their age nearest birthday as of the effective date of the policy and do not automatically change with increasing age. Rates for children to be covered as dependents do not vary by age and are charged for each child to be covered. When Maternity Benefits are included in the policy (and they are included only if selected by the Group Policyholder and only when husband and wife are to be insured under the same Converted Policy), an additional rate for Maternity is charged but only for the female Applicant or female spouse as the case may be. Rates are determined for each coverage for each individual to be insured under the policy and the total premium for the policy will be the sum of the individual rates.

QUARTERLY¹ PREMIUM RATES FOR "PERSONAL HEALTH POLICY—GROUP CONVERSION"

[Not applicable to California or New York conversions]

Age nearest birthday at effective date of policy	Amount of daily hospital benefit									
	\$6	\$7	\$8	\$9	\$10	\$11	\$12	\$13	\$14	\$15
HOSPITAL EXPENSE										
A. Male applicant:										
18 to 39.....	\$3.83	\$4.47	\$5.10	\$5.74	\$5.38	\$7.02	\$7.66	\$8.29	\$8.93	\$9.57
40 to 44.....	4.26	4.97	5.68	6.39	7.10	7.81	8.52	9.23	9.94	10.65
45 to 49.....	4.72	5.50	6.29	7.07	7.86	8.65	9.43	10.22	11.00	11.79
50 to 54.....	5.17	6.03	6.90	7.76	8.62	9.48	10.34	11.21	12.07	12.93
55 to 59.....	5.62	6.55	7.50	8.43	9.37	10.31	11.24	12.18	13.12	14.06
60 to 64.....	6.97	8.13	9.30	10.46	11.62	12.78	13.94	15.11	16.27	17.43
65.....	6.97	8.13	9.30	10.46	11.62	12.78	13.94	15.11	16.27	17.43
66.....	7.00	8.16	9.33	10.49	11.66	12.83	13.99	15.16	16.32	17.49
67.....	7.04	8.22	9.39	10.57	11.74	12.91	14.09	15.26	16.44	17.61
68.....	7.11	8.30	9.48	10.67	11.85	13.04	14.22	15.41	16.59	17.78
69.....	7.18	8.37	9.57	10.76	11.96	13.16	14.35	15.55	16.74	17.94
70.....	7.26	8.47	9.68	10.89	12.10	13.31	14.52	15.73	16.94	18.15
71.....	7.33	8.55	9.78	11.00	12.22	13.44	14.66	15.89	17.11	18.33
72.....	7.43	8.67	9.90	11.14	12.38	13.62	14.86	16.09	17.33	18.57
73.....	7.54	8.79	10.05	11.30	12.56	13.82	15.07	16.33	17.58	18.84
74.....	7.61	8.88	10.15	11.42	12.69	13.96	15.23	16.50	17.77	19.04
75.....	7.72	9.00	10.29	11.57	12.86	14.15	15.43	16.72	18.00	19.29
76.....	7.78	9.08	10.38	11.67	12.97	14.27	15.56	16.86	18.16	19.46
77.....	7.82	9.12	10.42	11.73	13.03	14.33	15.64	16.94	18.24	19.55
78.....	7.84	9.14	10.45	11.75	13.06	14.37	15.67	16.98	18.28	19.59
79.....	7.87	9.18	10.50	11.81	13.12	14.43	15.74	17.06	18.37	19.68
80 and over.....	7.88	9.20	10.51	11.83	13.14	14.45	15.77	17.08	18.40	19.71
B. Female applicant, female spouse, or male spouse:										
18 to 39.....	5.05	5.89	6.73	7.57	8.41	9.25	10.09	10.93	11.77	12.62
40 to 44.....	5.64	6.58	7.52	8.46	9.40	10.34	11.28	12.22	13.16	14.10
45 to 49.....	6.23	7.27	8.30	9.34	10.38	11.42	12.46	13.49	14.53	15.57
50 to 54.....	6.80	7.94	9.07	10.21	11.34	12.47	13.61	14.74	15.88	17.01
55 to 59.....	6.80	7.94	9.07	10.21	11.34	12.47	13.61	14.74	15.88	17.01
60 to 64.....	6.97	8.13	9.30	10.46	11.62	12.78	13.94	15.11	16.27	17.43
65.....	6.97	8.13	9.30	10.46	11.62	12.78	13.94	15.11	16.27	17.43
66.....	7.00	8.16	9.33	10.49	11.66	12.83	13.99	15.16	16.32	17.49
67.....	7.04	8.22	9.39	10.57	11.74	12.91	14.09	15.26	16.44	17.61
68.....	7.11	8.30	9.48	10.67	11.85	13.04	14.22	15.41	16.59	17.78
69.....	7.18	8.37	9.57	10.76	11.96	13.16	14.35	15.55	16.74	17.94
70.....	7.26	8.47	9.68	10.89	12.10	13.31	14.52	15.73	16.94	18.15
71.....	7.33	8.55	9.78	11.00	12.22	13.44	14.66	15.89	17.11	18.33
72.....	7.43	8.67	9.90	11.14	12.38	13.62	14.86	16.09	17.33	18.57
73.....	7.54	8.79	10.05	11.30	12.56	13.82	15.07	16.33	17.58	18.84
74.....	7.61	8.88	10.15	11.42	12.69	13.96	15.23	16.50	17.77	19.04
75.....	7.72	9.00	10.29	11.57	12.86	14.15	15.43	16.72	18.00	19.29
76.....	7.78	9.08	10.38	11.67	12.97	14.27	15.56	16.86	18.16	19.46
77.....	7.82	9.12	10.42	11.73	13.03	14.33	15.64	16.94	18.24	19.55
78.....	7.84	9.14	10.45	11.75	13.06	14.37	15.67	16.98	18.28	19.59
79.....	7.87	9.18	10.50	11.81	13.12	14.43	15.74	17.06	18.37	19.68
80 and over.....	7.88	9.20	10.51	11.83	13.14	14.45	15.77	17.08	18.40	19.71
C. Each child of applicant:										
All ages.....	2.05	2.39	2.74	3.08	3.42	3.76	4.10	4.45	4.79	5.13
D. Maternity:²										
Female applicant or female spouse:										
18 to 39.....	1.76	2.05	2.34	2.64	2.93	3.22	3.52	3.81	4.10	4.40
40 to 44.....	1.16	1.36	1.55	1.75	1.94	2.13	2.33	2.52	2.72	2.91
45 to 49.....	.58	.67	.77	.86	.96	1.06	1.15	1.25	1.34	1.44
50 and over.....	0	0	0	0	0	0	0	0	0	0

Footnote at end of table.

	Physician's in-hospital medical expense	Surgical expense maximum schedule	
Age nearest birthday at effective date of policy		\$200	\$300
Physician's In-Hospital Medical Expense—Surgical Expense			
E. Male applicant:			
18 to 39	\$0.76	\$2.23	\$3.35
40 to 44 .....	.82	2.50	3.75
45 to 49 .....	.89	2.50	3.75
50 to 54 .....	.96	2.89	4.34
55 to 59	1.04	2.89	4.34
60 to 64	1.13	3.06	4.59
65 to 69	1.25	3.06	4.59
70 to 74	1.44	3.06	4.59
75 and over	1.61	3.06	4.59
F. Female applicant, female spouse or male spouse:			
18 to 39 .....	.83	3.41	5.12
40 to 44 .....	.88	3.41	5.12
45 to 49 .....	.93	3.41	5.12
50 to 54 .....	.98	3.41	5.12
55 to 59	1.05	3.41	5.12
60 to 64	1.13	3.06	4.59
65 to 69	1.25	3.06	4.59
70 to 74	1.44	3.06	4.59
75 and over	1.61	3.06	4.59
G. Each child of applicant:			
All ages .....	.35	1.45	2.18

¹ Annual premiums are determined by multiplying the quarterly premiums by 4; semiannual premiums are determined by multiplying the quarterly premiums by 2.

² Use only when an applicant and spouse (with or without children) are to be insured. Charge for only 1 person, the adult female, and use same column as used for hospital expense.

CONVERSION PRIVILEGE—GROUP ACCIDENT AND HEALTH INSURANCE

(Applicable to Persons under Age 65 who are not entitled to Medicare Coverage)

The Conversion Program as outlined herein is available to Eligible Group Policyholders and Eligible Applicants in the District of Columbia and all States except: California, Hawaii, Kansas, New York, and the Virgin Islands.

Home Office Representatives will be kept informed of the change in status of these jurisdictions as they occur. At the present time, we do not intend to have a Conversion Program available in Canada or Puerto Rico. Pending final word on the outcome of filings made in all jurisdictions, material contained in the Group Manual describing the Conversion Program in force prior to May 1, 1968 should be retained. Employees making application for a converted policy who reside in jurisdictions which haven't as yet approved the new program will be insured in accordance with the provisions of the Conversion Program in force prior to May 1, 1968.

General

Subject to underwriting rules, a Conversion Privilege may be added, by amendment, to Group Accident and Health coverages other than Group Accidental Death and Dismemberment and Group Accident and Sickness coverages.

This Privilege will permit individuals, whose Accident and Health Insurance under the Group Policy terminates because of certain specific reasons, to apply for and have issued, without evidence of insurability, a non-group Personal Health Insurance policy insuring themselves and, if desired, their dependents whose Group Accident and Health Insurance also terminates.

The Converted Policy will be known as a "Personal Health Policy", and will be renewable on any premium due date at the option of the Company, until the latest date of expiration of coverage of all Covered family members. The type of coverage and amount of benefits available for an individual converting from a specific Group Policy will be controlled by the Group Policyholder's and the individual's selection of coverage and benefits in accordance with applicable underwriting rules. Attention is directed to the fact that the maximum period of coverage for any person insured under the policy will not extend beyond the date an individual attains his 65th birthday or becomes entitled to "Medicare" coverage, whichever occurs earlier. Also, that Maternity coverage, if elected by the Group Policyholder, provides benefits only when husband and wife are both insured under the same Converted Policy.

Where required by state insurance laws, certain endorsements will be attached to the standard Converted Policy form. These modifications, however, do not affect the general type of coverage or benefits of the policy.

The "Personal Health Policy" may be applied for only within 31 days of the date of termination of Group Accident and Health Insurance. In order to avoid having any period without coverage, such policies will always become effective on the date following the date of termination of the individual's Group Insurance. Policies may be issued on a quarterly, semi-annual, or annual basis. Sample policies, application forms, and premium tables with calculation instructions, will be available to applicant at the Policyholder's office and detailed instructions to the Policyholder for the administration of this part of his Group Program will be included in the Group Administration and Claims Manual furnished to him. Policies will be issued at the Home Office and all services in connection with the policy will be rendered to the Applicant directly from the Home Office. An outline of procedure for application and policy issue is contained herein under the heading "Procedure for Application and Policy Issue."

Group Premium Rates

Although initial or in force Group rates will not be increased because of the addition of the Privilege, the Policyholder desiring to include it in his program should be informed:

1. That an expense charge will be made under the dividend formula to cover certain additional administrative expenses of the Group Department resulting from the inclusion of the Privilege and

2. That rates for the Converted Policies have been established at a level we feel to be self-sustaining and, that the experience of all Converted Policies arising from all Group Policies having the Privilege will be pooled. If, under the pooling arrangement, losses develop in excess of those expected, an additional charge may be made, through the dividend formula, to Policyholders having the Conversion Privilege.

Underwriting Rules

Groups eligible

The Company desires that this Conversion Privilege be offered only when a definite request for it originates with a Group Policyholder or Prospect who has a special need for it; who is willing to cooperate in its administration; and, who is willing to assume the additional cost involved. Its availability will be limited generally to Policyholders having at least fifty employees and may be offered to new "Single Employer" cases without prior Home Office approval. On cases that are in force, or that are to be insured on other than a "Single Employer" basis, we will require prior Home Office approval because of the necessity of considering current Group experience and the facilities of the Policyholder for the proper administration of the program.

Because employees age 65 and over generally are entitled to the broad benefits of "Medicare" they will not be eligible for the "Conversion Privilege." If a Group Policyholder wishes to supplement "Medicare" benefits for his employees under the Group Policy, the Company is willing to consider such requests but any extension of this nature is subject to Home Office approval.

It is suggested that a Group Policyholder, having the Conversion privilege, continue Group Accident and Health Insurance on his employees (and their dependents) during any reasonable periods of temporary layoff rather than having a large number of Converted Policies issued for a short duration. The standard Group Policy permits this continuance to the end of the policy month next following the policy month in which the employee ceased active work. Where desired and in connection with the inclusion of the Conversion Privilege, the Company is willing to consider reasonable extensions of this period. The possibility of such an extension on any given case should be discussed with appropriate Group Insurance Underwriting personnel.

Individuals eligible to apply for or be covered under a "personal health policy—group conversion."

The following individuals are eligible for coverage under a Converted Policy upon termination of their Group Accident and Health Insurance provided they have been insured or covered under a Group Policy containing the Conversion Amendment; that such Group coverage is in force on, and does not terminate coincident with, the date the individual becomes eligible; that they are not otherwise eligible to be insured under the same Group coverage as employees or dependents; and, that application is made, and full first premium is paid, within 31 days of the date Group Insurance terminates.

A. Eligible to apply for and be covered under Converted Policy:

1. All employees under 65 years of age, who are not entitled to "Medicare" coverage whose Group Insurance terminates because of:

i. termination of employment,

ii. transfer out of the class of employees eligible for such insurance.

2. An employee's spouse under age 65 who is not entitled to "Medicare" coverage whose insurance under the dependent Group coverage terminates because of the death of the employee.

3. An employee's child whose insurance under the dependent Group coverage terminates because of reaching the maximum age under the Group dependent definition.

B. Eligible to be covered as dependents under Converted Policy.

1. Dependents, as defined in the Group Policy, of employees or of an employee's spouse outlined in 1 and 2 above. (Provision is made under the terms of the Converted Policy itself for the subsequent addition of certain dependents after the policy is issued—see General Provision 1 of the Converted Policy.)

Coverage or combination of coverages available for a group policyholder's selection under a conversion program; and conditions pertaining to such selection.

Subject to the Group Policyholder's selection in accordance with the conditions outlined below, the following coverage or combination of coverages are available under a Conversion Program:

A. Hospital Expense Insurance.

B. Hospital Expense and Physicians In-Hospital Medical Expense Insurance.

C. Hospital Expense and Surgical Expense Insurance.

D. Hospital Expense, Surgical Expense, and Physicians In-Hospital Medical Expense Insurance.

All of which exclude coverage for pregnancy. When the Group Policy, from which the Conversion Program arises provides pregnancy coverage for dependent wives, a Maternity coverage is available with A, B, C, or D above. This Maternity coverage will be included only in policies insuring husband and wife, and will be only for pregnancies concerning while husband and wife are insured under the Converted Policy.

The Group Policyholder will be permitted to select for inclusion in his Conversion Program any coverage or combination of coverages available provided similar coverage or combination of coverages is included under his Group Policy. If insurance on dependents is included in the Group Policy, a Group Policyholder electing a Conversion Program will be required to have it apply to eligible dependents as well as eligible employees. When the Conversion Program applies to dependents, the selected coverages must not exceed those that are included for dependents under his Group Policy, and the coverages for employees and dependents must be the same. For this purpose:

(a) the In-Hospital Medical coverage would be available to any Group Policyholder having In-Hospital Medical, Disability Medical or Comprehensive Medical Expense coverage, or Major Medical Expense coverage on a Supplemental basis with a reasonable deductible; and

(b) a group coverage of Major Medical Expense on a Comprehensive basis, with a reasonable deductible, and with or without underlying coverage, would be assumed to include all types of coverage available other than the Maternity coverage. If the Major Medical includes the special pregnancy coverage or if pregnancy coverage is included in the underlying coverages, the Maternity coverage of the Converted Policy may be selected.

Amounts of benefits available for a group policyholder's selection under a conversion program; and conditions pertaining to such selection:

Subject to the Group-Policyholder's selections in accordance with the conditions outlined below, the following amounts of benefits are available under a Conversion Program:

1. Hospital Expense Benefit:

i. Daily Hospital Benefit—A range from a minimum of \$10.00 to a maximum of \$35.00 (in full dollar units)

ii. Maximum Hospital Services Benefit—10 or 20 times the Daily Hospital Benefit

iii. Maximum Hospital Expense Benefit Period—31 days or 70 days

2. Physicians In-Hospital Medical Expense Benefit:

i. Daily Medical Benefit—\$3.00, \$4.00, or \$5.00

ii. Maximum Medical Benefit—31 or 70 days

3. Surgical Expense Benefit:

i. Maximum Surgical Expense Benefit (Schedule Maximum)—\$300, \$450, or \$600

4. Maternity Benefit:

i. Maximum Normal Maternity Benefit—10 times the Daily Hospital Benefit selected under the Hospital Expense coverage.

The Group Policyholder must select all the amounts of benefits, including the range of Daily Hospital Benefits and the Maximum Hospital Expense Benefit Period that are available for the coverages he has included in his program, except:

(a) the maximum amount of the range of Daily Hospital Benefit may never be in excess of the smallest such amount provided under the Group Policy for any individual but may be less than such amount if the Group Policyholder so elects;

(b) only one Surgical Maximum Amount may be selected by the Employer, either a \$300, \$450, or \$600 maximum, but in no event to exceed the approximately equivalent smallest plan now in effect under the Group Program. A special Surgical Schedule is used in the Converted Policy. This schedule when issued with a \$300 maximum benefit provides total benefits approximately equal to those which would be paid under a standard Group Policy Surgical Schedule with a \$200 maximum; and

(c) only one Physician's In-Hospital Medical Plan may be selected and may be either \$3.00, \$4.00 or \$5.00 for either a 31 or 70 day plan, but must not exceed the smallest plan in effect under the group policy, and it must always be for the same duration as that selected for the Maximum Hospital Expense Benefit.

If the Group Coverage includes Major Medical Coverage the Group Insurance Underwriting location servicing the case should be contacted and requested to establish the maximum benefit to be provided under the Converted Policy for the Hospital, Surgical and In-Hospital Medical Expenses Coverages.

When the Conversion Program applies to dependents, the selected amounts for employees and dependents must be the same.

Coverage or combination of coverages available to the applicant under a "personal health policy—group conversion" and conditions pertaining to the applicant's selection of coverages:

The coverages available for an Applicant and, if eligible, his dependents, are those selected by the Group Policyholder excluding any such coverage for which the employee, or his dependents who were insured under the Group Policy, were not covered. An Applicant must apply for the coverage or combination of coverages available to him except, when the Conversion Privilege applies to dependents, the Applicant may apply for a Converted Policy for:

(a) Himself only, or

(b) Himself and his eligible dependents. If he does apply for his eligible dependents, he must include all his eligible dependents except dependents who are in the armed forces. Although a Converted Policy would be issued in the name of an employee who at the time application is made is age 65 or over or entitled to Medicare benefits, coverage under the Policy would be limited to the employee's eligible dependents. He may not include any dependent who was not insured under the Group Policy as a dependent. (Provision is made under the terms of the Converted Policy for the subsequent addition of certain dependents after the policy is issued—see General Provision 1 of the Converted Policy.)

Amounts of benefits available to the applicant under a "personal health policy—group conversion" and conditions pertaining to the applicant's selection of amounts of benefits:

The amounts of benefits available for an Applicant and, if eligible, his dependents are those selected by the Group Policyholder. An Applicant must apply for the amounts of benefits available to him except, he may apply for only one amount of Hospital Expense-Daily Hospital Benefit, and that amount may be equal to or less than the maximum amount selected by the Group Policyholder but such amount must be a full dollar unit, not less than \$10.00 and the same for all persons to be insured under the policy.

Procedure for Application and Policy Issue

Applications will be secured by the Applicant from the Group Policyholder. An authorized Representative of the Group Policyholder should complete Part I of the reverse side of the application form. The Applicant should then complete the application in accordance with the instructions contained in Part II of the reverse side. It is suggested that, whenever possible, the application be com-

pleted in the office of the Policyholder and that the Policyholder render the applicant any assistance he may require. Copies of premium tables with calculation instructions will be furnished to the Policyholder for mailing with the application to any applicant who finds it inconvenient to come to the office or who may otherwise desire them.

Completed applications together with check, for the full first premium are to be mailed directly to the Group Records Division at the Home Office. After verification, they are referred to the Personal Health Division for the issuance of a Converted Policy. Where a Resident Licensed Agent's countersignature is required, policies will be sent to properly licensed Group Home Office Representatives who, after signing them, will return them to the Home Office.

The following States require countersignature by a Resident Licensed Agent in the space provided on the filing back of the policy form.

STATES

Alabama	Michigan	South Carolina
Colorado	Mississippi	Utah
Connecticut	New Hampshire	Vermont
Hawaii	New York	West Virginia
Illinois	North Carolina	Wisconsin
Kansas	North Dakota	Wyoming
Maine	Ohio	

Premium Rates for "Personal Health Policy—Group Conversion"

A "Personal Health Policy—Group Conversion" may be issued on a quarterly, semi-annual, or annual basis. Because of the wide range of benefits offered under the new Converted Policy premium rate tables are not being published in the Manual. However, each Home Office Representative has been furnished a copy of the complete table and the Policyholder will be furnished a copy of those rates applicable to the benefits he selects for the Converted Policy applicable to his employees.

Premium rates for adults are based on their age nearest birthday as of the effective date of the policy and do not automatically change with increasing age. Rates for children to be covered as dependents do not vary by age and are charged for each child to be covered. When Maternity Benefits are included in the policy (and they are included only if selected by the Group Policyholder and only when husband and wife are to be insured under the same Converted Policy), an additional rate for Maternity is charged but only for the female Applicant or female spouse as the case may be. Rates are determined for each coverage for each individual to be insured under the policy and the total premium for the policy will be the sum of the individual rates.

American Family Life Assurance Company of Columbus

Home Office: Columbus, Georgia 31902

IN CONSIDERATION of the application which is attached to and made part of this policy, and of payment of the premium set forth in the Policy Schedule (which is attached hereto and made a part of this policy), I HEREBY INSURE the insured as defined under the provisions of this policy, to the extent herein provided, against loss resulting from hospital confinement and other specified expenses (in accordance with the provisions and conditions and subject to the exceptions and limitations stated in this policy), incurred for the definitive treatment of the disease "cancer" as hereinafter defined, only, (hereinafter called "such sickness").

Part 1 BENEFITS FOR SUCH SICKNESS

A. If any insured shall become afflicted with cancer, as herein defined, which is first diagnosed as provided herein on or after the 90th day following the effective date shown in the Policy Schedule and while this policy is in force, provided such insured has never had any cancer diagnosed prior to such 90th day, the Company will pay indemnities according to the Schedule of Benefits, Part 3, and Extended Benefits, Part 1-B, for the expenses incurred by the insured, except as otherwise provided herein, for the definitive treatment of such cancer, beginning with the first day of hospital confinement during which such diagnosis is made or ten days prior to the date of such diagnosis, whichever is more favorable to the policyholder, but in no case shall more than the maximum benefits shown in the Schedule of Benefits, Part 3, and Extended Benefits, Part 1-B, for each service or benefit be paid with respect to any one insured, irrespective of the number of cancers or malignant tumors experienced by said insured. If for the first time in the entire lifetime of the insured cancer is first diagnosed on or after the 90th day following the policy date shown in the Policy Schedule, the Company will not deny a claim for such loss on the grounds that the illness existed prior to the effective date of coverage in this policy.

B. **EXTENDED BENEFITS:** During any period of hospitalization when any insured is confined to a hospital for less than 90 consecutive days for the definitive treatment of cancer, indemnities will be paid according to the Schedule of Benefits, Part 3.

If any insured shall be continuously confined to a hospital for an uninterrupted period exceeding 90 consecutive days for the definitive treatment of cancer, then on and after the 91st day of such continuous hospital confinement and until the termination of such period of continuous hospital confinement, in lieu of benefits under the Schedule of Benefits, Part 3, the Company will pay 100% of the usual and customary charges for hospital room and board, other hospital charges, and the services described in items 3 through 9 of Part 3, actually made by the hospital or others for such care and treatment on and after such 91st day, without any deduction for prior benefits paid; provided, that during such extended benefit period the Company's liability shall be limited to \$5,000.00 per month (30 days to be considered a month, with periods of less than 30 days limited proportionately). Benefits for subsequent periods of hospitalization of less than 90 consecutive days will be paid under the Schedule of Benefits, Part 3, subject to the limitations contained therein.

C. **MAXIMUM BENEFITS:** The sum total of all benefits payable to or on behalf of any one insured person under this policy shall not exceed \$50,000.00.

OPTION TO SURRENDER WITHIN TEN DAYS

This policy may be returned by the insured to any agent or to the Home Office of the Company within ten days of its delivery date for a complete refund of premium and cancellation of policy without cause.

IMPORTANT NOTICE: Please read the copy of the application attached to this policy. Carefully check the application and write to the Company within 10 days, if any information shown on it is not correct and complete. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

Part 2 CANCER DEFINED -- POSITIVE PATHOLOGY REQUIRED

A. Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, or Leukemia.

Such cancer as above defined must be positively so diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology to practice Pathologic Anatomy or by an Osteopathic Pathologist, upon the basis of a microscopic examination of fixed tissue, or preparations from the hemic system (either during the life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis does not meet this standard.

THE PROVISIONS on the following pages are part of this policy.

IN WITNESS WHEREOF, American Family Life Assurance Company of Columbus has caused this policy to be signed by its President and its Secretary at its Home Office in the City of Columbus, Georgia as of the Effective Date shown in the Policy Schedule.

George W. Jeter
George W. Jeter, Secretary

John B. Amos
John B. Amos, President

**CANCER POLICY
BENEFITS PROVIDED FOR HOSPITAL AND MEDICAL SERVICES FOR CANCER
GUARANTEED RENEWABLE
PREMIUMS ADJUSTABLE BY CLASS**

POST-MORTEM DIAGNOSIS

B. Whenever the requisite positive diagnosis of cancer can only be made post-mortem, the Company shall assume retroactive liability and its liability shall be limited to the period of time beginning with the date of the terminal admission to the hospital but in no event to exceed the portion of charges subject to indemnity incurred during the 45 days prior to the date of the demise of the insured.

EXCEPTIONS AND LIMITATIONS

C. This policy pays only for loss resulting from definitive cancer treatment, including only direct extension, metastatic spread (and/or its direct effects) or recurrence (and pathologic proof thereof shall be submitted to support such additional claims as provided under the terms of the policy). This policy does not cover any other disease or sickness or incapacity.

INSURED DEFINED

D. If this is an individual policy, as shown in the Policy Schedule, the word "insured" shall mean only the person named as the Insured in the Policy Schedule. Where type of coverage is shown as "Family" in such Schedule "an insured" shall include the person named in the Schedule, the spouse of the named insured and all of the dependent childrean of the named insured unmarried and under 21 years of age. The insurance on any child covered under the terms hereof shall terminate on the anniversary date of this policy following such child's twenty-first birthday or such child's marriage, whichever first occurs, but such termination shall be without prejudice to any claim originating prior thereto. The acceptance of premium by the Company after such date, or dates, shall be considered as premium for only the remaining persons who qualify as insureds under this provision. Provided further, that if on the policy anniversary when the last covered child attains age 21 years and either the insured or spouse is no longer covered due to death or due to payment of maximum benefits, if the Company bills and accepts the family unit premium then the last covered child's coverage shall continue to the end of the period for which said premium has been paid. Provided further that coverage shall be continued for any dependent child regardless of age who is incapable of sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to attainment of age 21. Proof of such incapacity and dependency must be furnished the Company by the named insured at least 31 days within the child's attainment of the limiting age. In event of the death of the named insured, the spouse shall, if alive and covered hereunder, become the named insured.

HOSPITAL DEFINED

E. Whenever used in this policy, the word "hospital" shall mean a legally operated institution which: maintains and regularly uses on its premises laboratory, x-ray equipment and operating room where surgical operations may be performed; maintains permanent and fulltime facilities for the care of overnight resident bed patients under the supervision of a licensed Physician; provides 24-hour-a-day nursing service by graduate Registered Nurses; and maintains on the premises the patient's written history and medical records. The word "hospital" shall not include any facility contracted for or operated by the United States Government for the treatment of members or ex-members of the armed forces, and shall not include any institution or part thereof used by an insured as a place for rehabilitation, rest, the aged, drug addicts or alcoholics, a mental institution, sanitarium, nursing or convalescent home, a long term nursing unit or geriatrics ward, or as an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Part 3**SCHEDULE OF BENEFITS FOR SUCH SICKNESS**

As provided in Part 1A hereof (Benefits for Such Sickness) the Company will pay indemnities according to the following Schedule of Benefits (maximum benefit amounts shown are for the entire lifetime of each insured, excepting as provided in Part 1B):

- HOSPITAL CONFINEMENT BENEFIT:** The Company will pay Fifty (\$50.00) Dollars per day for each of the first seven (7) days of each period of hospital confinement and Thirty (\$30.00) Dollars for each day thereafter. **EXCEPTION:** If less than thirty (30) days separates two periods of hospital confinement, then for purposes of calculating hospital confinement benefits under this section, such second period of hospital confinement shall be considered to be a continuation of the prior period of hospital confinement.
- DRUGS AND MEDICINE BENEFIT:** The Company will pay the actual charges made by the hospital for drugs and medicines administered while confined to the hospital, not to exceed 10% of the Hospital Confinement Benefit payable under Item 1 (Part 3) above, for each claim.
- SURGICAL BENEFIT:** When a surgical operation is actually performed on an insured for a condition which has been diagnosed as being cancer, the Company will pay the fee for such operation, including post-operative attendance, not to exceed the amount set opposite the name of the operation in the Schedule of Operations. If any operation for the treatment of cancer is performed other than those listed, the Company shall pay a comparably reasonable fee for such operation, but in no case shall such fee exceed \$500.00. Two or more surgical procedures performed through the same incision will be considered as one operation.
- ATTENDING PHYSICIAN BENEFIT:** If an insured, as the result of such sickness, shall require the services of a licensed physician, other than or in addition to the surgeon who performed surgery, the Company will pay the actual charge not to exceed Ten (\$10.00) Dollars per day for such doctor's visits to the insured while confined to the hospital. Not more than one doctor's visit per day will be allowed, the term "visit" shall mean an actual personal call by the doctor, and not more than Six Hundred (\$600.00) Dollars will be paid for all such visits.
- BENEFITS FOR NURSING SERVICES:** The Company will pay the actual expense incurred up to Twenty-Four (\$24.00) Dollars per day for nursing services on behalf of any insured hereunder who received full time and private care and attendance (other than that regularly furnished by the hospital) for registered graduate nurses or registered licensed practical nurses not related to the insured, when required and authorized by the attending physician in treatment of such sickness when confined to the hospital. Not more than Six Hundred (\$600.00) Dollars will be paid for all such services.
- RADIATION THERAPY BENEFIT:** The Company will pay the usual and customary charges made for treatment with x-rays, radium or radioactive isotopes of cobalt or other elements not to exceed a lifetime maximum of One Thousand (\$1,000.00) Dollars. This benefit does not include diagnostic use of x-rays, any other diagnostic procedure or laboratory tests related to radiation therapy.

Part 3 - Continued

SCHEDULE OF OPERATIONS

	Maximum Amount		Maximum Amount		Maximum Amount
ABDOMEN		AMPUTATIONS		GENITO-URINARY TRACT	
Complete resection of the stomach	\$400.00	Thigh, leg, or entire foot	\$300.00	Removal of kidney	\$400.00
Partial resection of the stomach	\$300.00	Arm, forearm, or entire hand	\$300.00	Removal of prostate, complete procedure	\$400.00
Resection of the small bowel	\$500.00	Fingers or toes only, each	\$ 50.00	Removal of uterus, tubes and ovaries	\$400.00
Resection of the ascending or transverse colon	\$300.00	BRAIN		MOUTH	
Combined abdominal perineal resection or cancer of the rectum or sigmoid	\$400.00	Complete removal of cancer of brain	\$500.00	Cutting operation for removal from: Mouth, tongue, tonsil, mucous membrane of the mouth	\$200.00
Colostomy or ileostomy	\$200.00	BREAST		NECK	
Resection of esophagus	\$500.00	Amputation of one breast	\$200.00	Complete resection of glands of the neck	\$400.00
Gastrostomy done in connection with esophagus	\$200.00	Amputation of both breasts	\$300.00	RECTUM	
Splenectomy	\$300.00	CHEST		Proctectomy	\$200.00
Complete cystectomy with ureteral transplant	\$500.00	Complete lobectomy	\$400.00	SKIN	
Simple excision of the bladder	\$200.00	EXTERNAL-GENITALIA		Cutting operation for removal from skin:	\$ 50.00
EYE		Women		SPINAL	
Enucleation with complete resection	\$200.00	Complete excision for removal of the vulva or vagina with regional lymph nodes	\$300.00	Operation with removal of portion of vertebra or vertebrae	\$400.00
		Cauterization of the cervix	\$ 50.00	THROAT	
		Men		Excision of larynx	\$200.00
		Cancer of penis - complete excision of regional lymph nodes	\$300.00	Thyroidectomy	\$150.00
		Orchiectomy - i.e. removal of testicles	\$200.00	Thyroid and radical complete removal of Thyroid gland (Goitre)	\$300.00

7. **ANESTHESIA BENEFIT:** The Company will pay actual charges not to exceed \$70.00 per operation (other than an operation for skin cancer) for either (a) the professional fee of an Anesthesiologist not employed by the hospital or (b) charges made by the hospital where anesthesia is administered by an Anesthetist employed by the hospital. Not more than \$50.00 will be paid for anesthesia in connection with skin cancer operations.

8. **BLOOD AND PLASMA BENEFIT:** The Company will pay the usual and customary charges for blood and blood plasma not to exceed a lifetime maximum of Three Hundred (\$300.00) Dollars for all cancers except leukemia, in which case the Company will pay the usual and customary charges for such products subject only to the overall maximum benefit stated in Part 1C.

9. **AMBULANCE BENEFIT:** The Company will pay the usual and customary charges made by a licensed or professional ambulance company for transporting the insured to or from the hospital in which the insured is admitted as a patient, not to exceed \$50.00 for each confinement, and not to exceed an aggregate maximum of \$500.00.

TERM

The term of this policy begins on the Effective Date shown in the Policy Schedule at 12:00 o'clock, noon, Standard Time, of the place where the insured then resides and ends at 12:00 o'clock, noon, the same Standard Time on the first Renewal Date. Each renewal term ends at 12:00 o'clock, noon, the same Standard Time, on the next following Renewal Date. Renewal Dates are determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule. An annual premium will maintain the policy in force for twelve months, semi-annual for six months, quarterly for three months. If the mode of payment is shown as "monthly," the term is for one month.

RENEWAL PROVISIONS

This policy may be renewed for successive terms for the lifetime of the insured at the established standard premium rate for the type of coverage in effect at the beginning of each term. The Company may change the established premium rate for all policies of this form number and type of coverage in force in the state in which the insured resides. In the event of a change in the established premium rate, the Company will notify the insured in writing, such notification to be mailed to the insured's last known address at least thirty (30) days before such change becomes effective. Changes in premium rate will not be made for reasons of age, sex or condition of health, or in any manner which would affect single policies.

Part 4

UNIFORM PROVISIONS

1. **ENTIRE CONTRACT; CHANGES:** This policy, including a copy of the application for same, the endorsements and the attached papers, if any, constitute the entire contract of insurance. No change in the policy shall be valid until approved by an executive officer of the Insurance Company and unless such approval signed by the insured be endorsed hereon or attached hereto. No agent has authority to waive any of its provisions.

2. **TIME LIMIT ON CERTAIN DEFENSES:** (A) After two years from the effective date of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period. The wording as used above "except fraudulent misstatements" shall not apply in Georgia.

(B) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the effective date of this policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

POLICY SCHEDULE & COPY OF APPLICATION ATTACHED HERE

Part 4 - Continued

3. **GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.
4. **REINSTATEMENT:** If any renewal premium be not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Insurer or by any agent duly authorized by the Insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt, unless the Insurance Company has previously notified the Insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such sickness as may begin more than ten days after date of reinstatement. In all other respects the Insured and Insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.
5. **NOTICE OF CLAIM:** Written notice of claim must be given to the Insurance Company within sixty days after the occurrence of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or the Beneficiary to the Insurance Company at Columbus, Georgia or to any authorized agent of the Insurance Company, with information sufficient to identify the Insured, shall be deemed notice to the Insurance Company.
6. **CLAIM FORMS:** The Insurance Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.
7. **PROOFS OF LOSS:** Written proof of loss must be furnished to the Insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the Insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
8. **TIME OF PAYMENT OF CLAIMS:** Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid each 4 weeks, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.
9. **PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. Any accrued indemnities unpaid at the Insured's death may at the option of the Insurer be paid to any assignee or to the estate of the Insured.
10. **PHYSICAL EXAMINATION:** The Insurance Company at its own expense shall have the right and opportunity to examine the person of the Insured when and as often as it may reasonably require during the pendency of a claim hereunder.
11. **LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of six years after the time written proof of loss is required to be furnished.

ADDITIONAL PROVISIONS

1. **CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.
2. **OTHER INSURANCE IN THIS INSURER:** Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

THIS POLICY SHOULD BE VIEWED AS A SUPPLEMENT TO YOUR PRESENT HEALTH INSURANCE



Good News

Medical bills marked "Paid" are welcome news to the sick. How will your bills be covered? Health Insurance seldom covers all of your medical expenses and Cancer has all the expenses of any illness, plus, in many cases, its own expensive requirements, for confinement, treatment, surgery, medication and other costs. Help your present insurance meet the medical expenses of Cancer. Secure CancerCare for your family. When you're sick, the Difference Between Costs and Coverage Comes From YOUR Pocket.

CANCER'S SEVEN WARNING SIGNALS

- Change in bowel or bladder habits
- A sore that does not heal
- Unusual bleeding or discharge
- Thickening or lump in breast or elsewhere
- Indigestion or difficulty in swallowing
- Obvious change in wart or mole
- Nagging cough or hoarseness

IF YOU HAVE
A WARNING SIGNAL,
SEE YOUR DOCTOR!



Form A-4475 Neb.

© 1970

CANCERCARE™

By American Family Life Assurance Company of Columbus

The Company

American Family Life is the world's leading insurer of insurance specifically against Cancer. It has qualified to offer, through local representatives, this insurance in your state.

Age & Health

CancerCare may be purchased by anyone of any age in any state of health who has never had Cancer.

Pre-Existing

CancerCare covers Cancer which is first diagnosed by a qualified pathologist 90 days after date of policy issue whether or not you have had symptoms prior to that date.

Pays To You

CancerCare is your insurance. Its benefits are paid directly to you or whom you designate.

Maximum Coverage

Only one policy on this plan will be issued to any individual.

Other Insurance

CancerCare is intended to supplement your existing health insurance program to better provide for the unusual expenses of Cancer; therefore, the policy contains no provisions reducing benefits because of Medicare or any group or individual insurance you may carry.

Guaranteed Renewable

Premiums Adjustable by Class

CancerCare can be cancelled only by the Insured. The Plan is renewable for life, at then current premium rates. Rates may be changed only if changed on all policies in force in your state.

Limitations & Exclusions

This plan pays only for loss resulting from definitive cancer treatment, including only direct extension, metastatic spread or recurrence. Positive pathologic proof of diagnosis is required.

PREMIUM RATES

	Ann.	Semi-Ann.	Qtr.	Mo.
R-1 DIRECT				
Individual	\$40.00	\$20.00	—	—
Family	\$60.00	\$30.00	—	—
R-2 PAYROLL				
Individual	\$30.00	\$15.00	\$ 7.50	\$ 2.50
Family	\$45.00	\$22.50	\$11.25	\$ 3.80
R-3 ASSOCIATION				
Individual	\$33.00	\$17.50	—	—
Family	\$50.00	\$26.00	\$13.25	—

Minimum Number Required
for Payroll - 5 / Association - 10

BASIC BENEFITS

All limits shown are lifetime limits for each person covered.



HOSPITAL CONFINEMENT — \$50 daily first seven days; \$30 per day thereafter. Readmission 30 days after discharge starts \$50 daily payment again.



DRUGS & MEDICINE — Up To 10 percent of the total payable Hospital Confinement Benefits for drugs and medicines administered in hospital and charged to Insured.



SURGICAL — \$50 to \$500 each operation, Schedule in Policy. No limit on number of operations.



PHYSICIAN — Up to \$10 daily in hospital for physician other than surgeon. Limit \$600.



PRIVATE NURSING — Up to \$24 daily in hospital, as required, for R.N. or L.P.N. Limit \$600.



X-RAY RADIUM — Up to \$1,000 for X-Ray, Radium, Cobalt Therapy, in or out of hospital. Excludes Diagnostic Procedures. Limit \$1,000.



ANESTHESIA — Actual expenses for professional fees up to \$70 on each internal operation, \$30 for Skin Cancer. No limit on number of operations.



BLOOD & PLASMA — Up to \$300 for actual charges made to Insured. No limit on Leukemia except policy maximum. Limit \$300 for other cancers.



AMBULANCE — Up to \$50 each confinement, to and from hospital where Insured admitted as patient. Limit \$500.

EXTENDED BENEFITS

FOR HOSPITAL CONFINEMENTS EXCEEDING 90 CONSECUTIVE DAYS THE COMPANY WILL PAY 100%

of the actual charges for hospital care and treatment
UP TO \$5,000 PER MONTH
without any deduction for sums previously paid
beginning with the 91st day of confinement
until discharge from hospital.

Benefits shall not exceed a total of \$50,000 per insured person. The company by stating this limitation does not intend to imply that this maximum coverage represents the expenses that are sustained by all cancer victims. On the contrary, such costs are presented only in those unusual cases requiring long term hospitalization.

American Family Life Assurance Company
Home Office: Columbus, Georgia 31902

CancerCare is a trademark of American Family Life.
Reproduction of this brochure, in whole or in part, is prohibited.

Why This CancerCare Plan?

1. Why do I need Cancer insurance?

The National Cancer Institute reports that Cancer will strike two families in three and this disease is the leading cause of death in women from ages 30 to 54. Overall, Cancer is the second leading cause of death of all age groups. Cancer is often a lingering disease which requires repeated, extensive treatment and results in the victim's being unable to work. This policy should be viewed as a supplement to your present health insurance.

2. What medical information do you need?

The only medical question is whether you have had Cancer positively diagnosed. If not, you may buy the policy.

3. Can this Plan be canceled by the Company?

No. The only way the American Family CancerCare Plan may be canceled is through the insured's not paying the premium.

4. Must I be hospitalized to receive benefits from this Plan?

No. As stated fully in the policy, many benefits do not require hospitalization.

5. When does this Plan become effective?

Full coverage under this Plan is available 90 days following the effective date of the policy.

6. What benefits do I receive for drugs and medicine?

You will be reimbursed actual charges made by the hospital for the drugs and medicines you use up to an amount not to exceed 10% of the benefits payable for Hospital Confinement.

7. If there is a history of Cancer in my family, may I still purchase and at the same premium?

Yes, It has been our experience that those most closely related to the expense of Cancer are the most anxious to secure necessary financial protection.

8. What is the age limit on purchase of this policy? What effect does age have on this policy?

Full benefits are paid regardless of age, and you may continue your policy for the rest of your life.

9. Must I be released from the hospital before I can collect benefits?

No. Benefits are payable to the insured as the expenses are incurred, on a monthly basis if he chooses. Release from the hospital, or from a doctor's care, is not necessary for you to begin receiving payments.

10. Does this Plan pay directly to me or the hospital?

Benefits from the American Family CancerCare Plan are paid directly to the insured or to whomever he designates.

11. What is meant by positive pathological diagnosis of Cancer?

It is a microscopic examination of human tissue or fluid by a pathologist to determine if there is a positive malignancy.

12. What forms of Cancer are covered?

All Cancer diagnosed as such by a pathological tissue examination, a standard medical practice, including leukemia and Hodgkins disease.

13. What does pre-existing condition mean?

As used in this Brochure, pre-existing conditions refer to the presence of Cancer, with or without symptoms, prior to the time a positive pathological diagnosis is made.

14. Who is included on a family policy?

The insured, spouse and dependent unmarried children to age 21, or to age 23 if full-time students. (Handicapped dependents continued as provided by statute.)

15. What treatment is covered by the Plan?

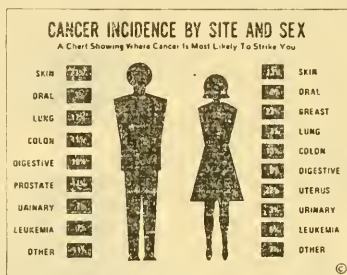
X-ray and radium therapy, radio-cobalt and other radioactive isotopes, chemotherapy, and surgery are covered by the policy. (Diagnostic x-ray and other diagnostic procedures are expressly excluded from the policy.)

16. Does this Plan cover me in a veterans hospital, a government hospital, a nursing home or an extended care facility?

No, these institutions are not included in the classes of organizations recognized as hospitals for the purposes of this policy.

17. If I am hospitalized twice or more in a year, how much will the Plan pay on my hospital expense?

The number of hospitalization periods in a year makes no difference at all in the payment of claims excepting that if thirty days or more separate two successive periods of hospitalization, the hospital confinement benefit is paid at the \$50-daily rate for the first seven days of the second confinement as if no previous confinement had occurred.



American Family CancerCareTM Plan

CANCER

INSURANCE
UP TO
\$23,760.00

**A
N
C
E
R**

STRIKES

- ONE IN EVERY FOUR AMERICANS
- IN TWO OUT OF THREE FAMILIES
- AT ANY AGE, IN ANY GROUP

KILLS

- 7 TIMES THE RATE OF AUTO ACCIDENTS
- 1 OUT OF EVERY SIX AMERICANS
- MORE AMERICANS EVERY YEAR

TREATMENT

- IS OFTEN IN DISTANT CITIES
- IS OFTEN THE MOST EXPENSIVE
- OFTEN IS A PROLONGED SERIES

CURES

- ARE POSSIBLE IN 1 OUT OF 3 CASES
- MAY REQUIRE EXTENSIVE TREATMENT
- MAY BE INCREASED BY EARLY DETECTION

Statistics shown compiled by
the American Cancer Society



MAXIMUM AGGREGATE TOTAL

HOSPITAL \$15,000.00
\$40.00 per day for seven days; \$20.00 per day thereafter.

SURGICAL \$3,000.00
\$30.00 to \$500.00 per operation as outlined in Schedule of Operations. Hospital or doctor's office.

ANESTHESIA \$700.00
Maximum \$70.00 per operation; limit \$30.00 for Skin Cancer operation.

X-RAY RADIUM \$1,000.00
X-Ray Radium and Radioactive Isotope Therapy; excluding diagnostic X-ray.

NURSING \$500.00
Up to \$24.00 daily, home or hospital, for Registered Graduate Nurse, as required.

PHYSICIAN \$500.00
\$10.00 daily in hospital. Maximum 1 visit per day; pays in addition to surgery.

BLOOD AND PLASMA \$300.00
Usual and customary charge paid by insured.

AMBULANCE \$100.00
To and from hospital where Insured admitted as patient.

TRANSPORTATION \$500.00
Legal residence to nearest hospital with treatment facilities not available locally; at doctor's direction; air or rail.

PAYS IN ADDITION TO

ALL OTHER INSURANCE

COVERS PRE-EXISTING CONDITION
AFTER 120 DAYS PROVIDING CANCER
HAS NOT BEEN DIAGNOSED PRIOR

LIMITATIONS & EXCLUSIONS

Policy Limited to Cancer

Dependent children coverage terminates at age 19 or upon marriage — Covers only cancer which is first diagnosed, as defined in the policy, on or after the 120th day following the policy effective date.

This policy is renewable for life at the option of the owner of this policy at such premium rate that shall be in effect at the date of each renewal. The Company may change premiums only on date of renewal, on all plans, within the state, by class only, and not by age, sex or health condition.

ADDITIONAL BENEFIT

AN AMOUNT IN CASH EQUAL TO 10% OF CLAIM PAID TO COMPENSATE THE INSURED FOR NON-MEDICAL LOSS CONNECTED WITH THE SICKNESS, SUCH AS HOUSEHOLD EXPENSES, ETC.

BENEFITS UP TO \$23,760.00
ON EACH INSURED PERSON

RATES

Association Groups

	A	SA	Q
INDIVIDUAL	\$23.00	\$12.00	
FAMILY	\$37.00	\$19.00	\$10.00

American Family Life Assurance Company
Home Office: Columbus, Georgia 31902

Why This Cancer Expense Plan?

1. Why do I need Cancer insurance?

The American Cancer Society reports that Cancer will strike two families in three and that this disease is the leading cause of death from ages 30 to 54. Overall, Cancer is the second leading cause of death of all age groups. Cancer is usually a lingering disease which requires repeated, extensive treatment and often results in the victim's being unable to work. This policy should be viewed as a supplement to your present insurance policy. U. S. Surgeon General William Stuart reveals Major Medical pays only 35% of the Insured's medical expenses.

2. Does this Plan pay in addition to other insurance, Medicare, and any other health payment plan I or my family may have?

Yes, the American Family Cancer Expense Plan pays regardless of any other health insurance plan the insured has.

3. Can this Plan be canceled by the Company?

No. The only way the American Family Cancer Expense Plan may be canceled is through the Insured's not paying the premium.

4. Must I be hospitalized to receive benefits from this Plan?

No. As stated fully in the policy, nursing services, surgical benefits, defined treatment, and special bonus benefits do not require hospitalization.

5. When does this Plan become effective?

Full coverage under this Plan is available 120 days following the effective date of the policy as shown in the Schedule on page four of the policy.

6. What does the "10% Extra" on each claim mean?

If a valid claim is \$5,000, for example, a sum equal to ten percent or \$500 would be added to the claim payment to reimburse the Insured for non-medical losses connected with Cancer.

7. If there is a history of Cancer in my family, may I still purchase and at the same premium?

Yes. Except family members with positively diagnosed cancer are not covered. It has been our experience that those most closely related to the expense of Cancer are the most anxious to secure necessary financial protection.

8. What is the age limit on purchase of this policy? What effect does age have on this policy?

Your age makes no difference as to purchase, coverage, or continuation of the policy. Benefits are the same regardless of age.

9. If I am hospitalized twice or more in a year, how much will the Plan pay on my hospital expense?

If the periods of hospitalization are separated by more than thirty days, each admission begins with the higher daily payment.

10. Does this Plan pay directly to me or the hospital?

Benefits from the American Family Cancer Expense Plan are paid directly to the Insured or to whomever he designates.

11. What is meant by positive pathological diagnosis of Cancer?

It is a microscopic examination of human tissue or fluid by a pathologist to determine if there is a positive malignancy.

12. What forms of Cancer are covered?

All Cancer diagnosed as such by a pathological tissue examination, a standard medical practice, including leukemia and Hodgkins disease.

13. What does pre-existing condition mean?

As used in the American Family Cancer Plan, pre-existing condition is construed to acknowledge liability after the policy has been in force for a period of 120 days — provided a positive diagnosis of Cancer has not been made.

14. If I leave my present employment insured under payroll deduction or direct billing, can I continue my Plan?

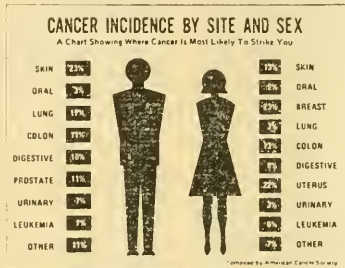
Yes, on individual rate basis. There is no waiting period or other evidence of insurability required for you to continue this Plan should employment terminate or you leave a direct billing group.

15. Who is included on a family policy?

A family policy includes the husband, wife, and dependent children, natural, adopted, or stepchildren. Dependent children's coverage terminates at age 18 or 19 (depending upon state) or as specified in the policy.

16. What treatment for Cancer is covered by the Plan?

X-ray and radium therapy, radioactive isotopes including chemo-therapy, and surgery are covered by the policy. (Diagnostic x-ray and other diagnostic procedures are expressly precluded from the policy.)



American Family Cancer Expense Plan

BOSTON PUBLIC LIBRARY



3 9999 05705 6655

